NEUROSIS AND THE MENTAL HEALTH SERVICES

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NEUROSIS
AND THE
MENTAL HEALTH SERVICES

BY

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FOREWORD BY

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FOREWORD

DR. BLACKER describes in the first chapter of this book the origin of the survey of psychiatric out-patient facilities of England and Wales. The matter was first raised in March 1942, and work was begun in October of that year.

Changes were then in the air, and the time seemed ripe for a general stock-taking of our medical services. It seemed appropriate that the survey should be planned with an ulterior as well as an immediate objective. The immediate purpose of the survey was to bring about a better co-ordination and distribution during the war of the country's psychiatric resources which had been depleted by the demands of the fighting services and the E.M.S. The ulterior purpose it could be made to serve was related to the integration of the country's health services after the war. At the beginning of November 1942, I discussed his plans with Dr. Blacker, and I encouraged him to take the wider issues into account both in conducting the survey and in writing his report.

The essential feature of the completed document is that it submits quantitative proposals for the organization of a mental health service in England and Wales. (Scotland was separately surveyed.) Three principles are embodied in these proposals. They relate to the future rôle of the eleven universities containing medical schools, to the incorporation of the mental in the general health service, and to the provision which might be made for a hypothetical population of a million, treated as an administrative unit.

These proposals are, as far as Dr. Blacker is aware, in general consonance with the views expressed by those organizations concerned with mental health which have appointed planning committees and have published reports. But Dr. Blacker is in a position to take his suggestions a stage further than the others. He has attempted to embody in quantitative terms the generalized propositions of the planning committees. In the reorganization of any public service, two questions present themselves: what kind of provisions we want, and on what scale. In this volume will be found suggestions as to both. The numerical proposals therefore arise from the main finding of the survey—the wide disparities found to exist between the mental health services of different regions of the country.

The neurosis survey has been officially sponsored by the Ministry of Health. The factual results and a discussion of their interpretation will be found in Parts I and IV of this report. Parts II and III contain respectively long and short term proposals for future reorganization. These proposals are not to be regarded as official or as necessarily expressing either the views or the policy of the Ministry of Health. They are the personal views of Dr. Blacker and are published exactly as he wrote them, without official comment or censorship. As he

remarks on pages 120–125 the report provides a basis for a more detailed and practical discussion than has hitherto been possible—a discussion concerned not only with general principles, but also with ways and means. The report, while dealing with work sponsored in the first instance by the Ministry of Health, is in respect of authorship a private document. The reactions it evokes will be taken into account in the framing of future policies.

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September 1945.

AUTHOR'S PREFACE

ACKNOWLEDGMENTS: ARRANGEMENT OF THE REPORT: REGIONS: TERMINOLOGY.

1. Acknowledgments.

In the collection of material for the neurosis survey and in the preparation of this report, I have received much help from many quarters. To numerous persons and organizations I am in debt. The influence of the report of the Feversham Committee will be apparent to all readers. Professor Major Greenwood and Dr. Lewis Faning have given most valuable guidance on the statistical presentation of the findings of the investigation. Dr. Lewis Faning has examined with meticulous care an unwieldy bulk of indigestible material and I have immensely benefited from his vigilant, constructive and simplifying criticisms. Professor J. M. Mackintosh, Dr. Bernard Hart, Dr. Rees Thomas, Mr. P. Barter, Dr. Aubrey Lewis and Mr. J. E. Pater have given valued advice on questions of general policy. By the teams of regional investigators whose names are given in Appendix IV, the factual material was collected on which the report is based. To them and to the staffs of the many psychiatric clinics who filled in a rather difficult questionnaire during a period of pressure and stress, my sincere thanks are due. To Dr. W. C. M. Scott and to Miss Dorothy Thomas of Cefn Coed Mental Hospital, a special tribute is paid for the very high standard of the report on Region VIII. From Dr. R. S. P. Schilling and Dr. May Smith of the Industrial Health Research Board, from Dr. W. Blood, the Hon. Secretary of the Association of Industrial Medical Officers, from Mr. R. R. Hyde of the Industrial Welfare Society, and from the medical officers of numerous factories and other concerns employing labour, I have received unstinted help.

In the sphere of children's services, I am in debt to Dr. C. J. C. Earl and Dr. Frank Bodman, to Drs. Alan Maberley and R. G. Gordon of the Child Guidance Council, to Dr. C. L. C. Burns and to Dr. Mary Capes. Many professional and voluntary organizations have helped. I have received valuable information and assistance from Dr. Doris Odlum, Chairman of the Psychological Group of the British Medical Association, from Dr. Gordon Masefield of the Royal Medico-Psychological Association, from Miss Evelyn Fox, Hon. Secretary of the Provisional National Council for Mental Health and from the Council's regional representatives, from Mr. L. T. Feldon, Secretary of the Mental Hospitals Association, from Mr. George Gibson, Secretary of the Mental Hospital and Institutional Workers Union, from Miss de Vere Hunt, Secretary of the National Council for Mental Hygiene, from Miss Clement Brown and Mrs. Edkins of the Association of Psychiatric Social Workers, from Miss L. G. Fildes of the Committee of Professional Psychologists (Mental Health), from Miss I. F. Hilton of the Association of Occupational Therapists, from Col. Henry Yellow-

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And last but not least, help of every kind has been generously given by numerous persons in the Ministries of Health, Education, Pensions, Supply, Labour and National Service, and in the Home Office, the General Register Office and the Board of Control.

Finally, I should like to make it clear that though I have received every assistance from the persons above named, none is to be held responsible for any aspect of the report. For the accuracy of the factual material and for the recommendations which are submitted, nobody is to be held accountable but myself.

2. Arrangement of the Report.

The report consists of an introduction, four parts and some appendices.

The introductory chapter describes the origins, history, objects and scope of the survey.

Part I discusses the interpretations to be placed on the main findings.

Part II reviews the needs of the mental health services of the future in so far as these can at present be descried. The suggestions put forward are mostly tentative, and many of them will need reconsideration as the services take shape. Chapter XV (5) is written from a more personal standpoint than the rest of the report.

Part III, which is short, discusses the needs of the post-war 'transitional' period and of the present period. It contains some short-term suggestions and recommendations which are designed (i) to meet the needs of the abnormal phase which will intervene between the first mitigation of hostilities and the final attainment of peace; and (ii) to lay the foundations of the more permanent structure of the mental health services outlined in Part II.

Part IV gives the findings of the survey in a series of Tables.

This report contains no suggestions as to how the psychiatric services of individual regions or areas should be amplified, though several teams of regional investigators submitted valuable recommendations on this topic. The reports of regional investigators will, with their consent, be made available for the Authorities in their regions who will be responsible for organizing the psychiatric services.

3. Regions.

At the time of writing, the constitution of the future health services is undecided. Had I known what this constitution was to be, and in particular had I known how far the health services are to be organized in regions centering on universities, my task would have been easier. In this report, I have taken as the smallest administrative unit the Joint Authority covering an average population of about a million.

The first objective to be attained in what, for psychiatry, is bound to be a long-term plan concerns personnel. We need more and better-trained psychiatrists and mental nurses. The supply and training of psychiatrists will depend on the activity and the efficiency of the Teaching Psychiatric Units of Universities which are the centres of regions, each region containing on average from three to four Joint Authorities. I believe that very much will depend on these Teaching Units, to which a key chapter is devoted below (Chapter VII). The influence of the Teaching Unit, which will be concerned with undergraduate and post-graduate education, should radiate throughout the region and permeate its Mental Health Services. Hence a well-regionalized organization of these Services (if administratively feasible) would, I believe, serve as a stimulus and a benefit to psychiatry.

4. Terminology.

Throughout this report, I have tried to avoid the use of psychiatric jargon, than which none is more exasperating to the general reader nor, in my experience, more inimical to clear thinking.

C. P. B.

December 1944.

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MAIN FINDINGS OF THE SURVEY

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GENERAL SUMMARY

THE findings which are most likely to be of general interest are the following :

1. Between 1938 and 1942 there has been an increase in the numbers and proportions of neurotic patients seen at 216 psychiatric clinics in England and Wales. But this increase of cases seen at clinics may not reflect a real increase of neurosis attributable to the war. It is probably due in large part or entirely to a growing use of the country's psychiatric services by general practitioners, and might have occurred in the absence of war. There are no grounds for supposing that the war has caused an increase in the more serious forms of mental disorder requiring admission to hospital (pp. 14–17).

2. Cases of neurosis attributed by psychiatrists to the effects of air raids are astonishingly few. About one new case in thirty seen at out-patient clinics in 1940, 1941 and 1942 was a psychiatric air-raid casualty. Over a third of these patients had previously suffered from some psychiatric disability (p. 167).

3. There are very marked disparities in the psychiatric services available in different parts of the country. A good index is provided by the number of doctor-sessions per million of population: these range from 26·7 for the London Region to 4·9 in Wales (p. 140).

The following is a summary of the chapters of the report :

INTRODUCTION

CHAPTER I.—*Origins, History and Scope of the Survey*

The neurosis survey was first discussed in the spring of 1942 and begun in October of that year. Its original object was to throw light on how the psychiatric out-patient services of the country had been affected by the war, and on how the depleted psychiatric personnel might best be redistributed. But after the Beveridge Report was published in December 1942, it was realized that the survey's findings might serve a wider purpose in connection with the problems that will arise in post-war planning. The survey was carried out by teams of three investigators in each of the eleven civil defence regions of England and Wales ; and it was centrally co-ordinated at the Ministry of Health. Scotland was separately surveyed. The survey was primarily concerned with out-patient services; psychiatric in-patient facilities and special child guidance services were not included (pp. 1–3).

PART ONE

THE SURVEY : MAIN FINDINGS AND THEIR INTERPRETATION

CHAPTER II.—*Preliminary Notes : Circumstances affecting the Survey : Presentation of Findings*

A questionnaire was centrally devised and distributed by the regional investigators to the Directors of all psychiatric clinics. The question-

naire asked for figures relating to the four years 1938, 1940, 1941 and 1942. During these years there were 216 psychiatric clinics in the country. These have been divided into three groups which present different features—*i.e.* clinics situated in :

(A) County Boroughs outside the London Region (called large-town clinics) ;

(B) Administrative Counties outside the London Region (called small-town clinics) ; and

(C) The London Region.

Other circumstances affecting the survey are described (pp. 4–8).

CHAPTER III.—*Summary of Findings of the Neurosis Survey*
See pp. 9–13

CHAPTER IV.—*Questions arising from the Findings*

1. *Has there been a real increase in neurosis ?*

In 1942 more cases of neurosis (both proportionally to new patients and in round numbers) were seen at psychiatric clinics than in 1938. Does this increase of neurotics among clinic patients reflect a real increase of neurosis attributable to the war throughout the general population ? Reasons are given for thinking that the changes in question among clinic patients might have occurred in the absence of war and that they are not necessarily connected with a real increase of neurosis in the general population (pp. 14–15).

2. *Would a real increase in neurosis be detectable to-day ?*

Reasons are given for thinking that such an increase would not be detectable except in circumscribed areas where the many relevant factors affecting clinic attendances are known (pp. 16–17).

3. *Dual origins of out-patient psychiatric services.*

Some psychiatric clinics are autonomous products of Voluntary Hospitals, usually of their departments of neurology ; others have been established by Local Authorities as a result of powers conferred on them by the Mental Treatment Act. These two types of clinic show different features. The differences between the two types of clinic seem to be growing less with time (pp. 17–19).

4. *Central, Affiliated and Independent clinics.*

The Central and Affiliated clinics undertake area responsibilities ; the Independent clinic is usually the autonomous product of the Voluntary Hospital. It is desirable that more of the latter should develop area responsibilities and become central clinics (pp. 20–21).

CHAPTER V.—*Neurosis in Industry*

The views held and data provided by certain Industrial Medical Officers and others concerned with industrial problems are discussed. Definite conclusions about the incidence of neurosis in industry are

not easily reached for several reasons, of which one is the difficulty of distinguishing from genuine neuroses the ' reactive debilities ' produced by the aggravated current stresses of war-time. While there are good grounds for thinking that severe current stresses are producing unfavourable psychological effects, there is little evidence pointing to an increase in neurosis in a strictly defined sense. The means of detecting such an increase were for the most part not available. Difficulties of adjustment can be expected when the Forces are demobilized and prisoners of war repatriated on a large scale ; and latent neurosis may reveal itself in the civilian population when the stresses of war are relaxed. Suggestions are made for facilitating adjustment to industrial life (pp. 22–37).

PART TWO

POST-WAR PSYCHIATRIC SERVICES : LONG-TERM CONSIDERATIONS

CHAPTER VI.—*Introduction*

1. *Preventive psychiatry a mainly sociological problem.*

Psychiatric disorders would be reduced or mitigated by better education of adults in the sensible handling of children, by educational services wherein sub- and abnormalities of children were detected early ; by higher standards of nutrition, housing and town-planning ; by better industrial, occupational and social psychiatry ; by limitation of fertility of prolific and at the same time constitutionally inferior types. All these innovations belong to the province of sociology rather than of medicine (pp. 38–39).

2. *Rifts in psychiatry : its partial insulation from general medicine.*

Institutional psychiatry has developed as a segregated specialty somewhat cut off from general medicine. Until the Mental Treatment Act (1930) was passed, services for the diagnosis and treatment of neurosis mostly developed as an offshoot of general medicine, often from neurology. Child guidance began as an independent movement insufficiently linked with general medicine (paediatrics), and little related to institutional psychiatry. Testing procedures and vocational guidance have partly derived from non-medical psychology. Psychiatry has thus developed new growing points in what, for the institutional psychiatrist, is the outside world : these need to be integrated with general medicine and combined in a comprehensive mental health service (pp. 39–40).

3. *Priorities.*

Needs are reviewed in the following order of priority :

(i) Men and women psychiatrists of the right kind and of good abilities ;

(ii) Good all-round training for psychiatrists and mental nurses ;

(iii) Good accessory services in sufficient numbers;

(iv) Good buildings and material facilities.

It would be a mistake to embark on big schemes involving extensive buildings when adequate personnel is not available.

The needs of children should have priority in any scheme of preventive psychiatry (pp. 40–41).

CHAPTER VII.—*Training of Psychiatrists*

The subject can be considered from the standpoint of the curriculum and of the quality and range of the teaching.

The Royal College of Physicians has produced valuable reports dealing with the psychiatric curriculum, and with standards for specialists. The responsibilities of teaching will continue to lie with the medical schools of universities. Of these, a Teaching Psychiatric Unit, under the direction of a professor of psychiatry, should form an essential part. The possible activities of such a unit are outlined (pp. 42–45).

CHAPTER VIII.—*Training and Registration of Mental Nurses*

The recruitment and training of mental nurses are as important to the future of psychiatry as the equipment and quality of psychiatrists. Nursing questions formed no part of the neurosis survey, but several problems urgently call for attention (p. 46).

CHAPTER IX.—*Children's Services*

Psychiatric services for children are examined in the light of the Education Act and the White Paper 'Educational Reconstruction'. It is suggested that child guidance services be divided between *Child Guidance Centres* under Local Education Authorities and *Child Psychiatric Clinics* under the mental health services and forming part of Central Psychiatric Clinics. The latter would be constituent elements of key and of teaching hospitals with paediatric departments (pp. 47–54).

CHAPTER X.—*The Rôle of the Mental Hospital in a Mental Health Service*

In order to play their full part in a mental health service, Mental Hospitals should link themselves more closely with General Hospitals, establish more facilities for part-time service, and offer better prospects for clinicians. They might usefully develop further the part they are already playing in out-patient departments for neuroses and early psychoses, in child guidance services, in industrial and occupational psychiatry, in delinquency and criminal psychiatry and in rehabilitation services (pp. 55–61).

CHAPTER XI.—*Proposed Mental Health Services for a Population of a Million*

This is the longest and most important section of the report. A summary will be found on pages xx and xxi.

Chapter XII.—*The Medical Officer of Mental Health*

The co-ordination of the Mental Health Services under a Medical Officer of Mental Health has been widely advocated. This officer's duties are outlined. They might include the co-ordination of the following: psychiatric out-patient services; psychiatric beds outside Mental Hospitals; the ascertainment of mental defectives and their community care; problems of industrial and criminal psychiatry and of delinquency; co-operation with Education Authorities in administering special schools and hostels; the education of the public in mental health; and the carrying-out of surveys and follow-up inquiries. The Medical Officer of Mental Health would have dealings with many organizations and persons; and if his work developed fully, he would require a considerable staff, some of whom might usefully work on a half-time basis (pp. 86–90).

Chapter XIII.—*Accessory Services*

The services provided by psychiatric social workers, psychologists and occupational therapists are considered in the light of probable future demands and existing training facilities. It is concluded that, in all three services, training facilities will need to be expanded. It is recommended that the position be examined by an officially appointed committee (pp. 91–101).

Chapter XIV.—*Prevention of Mental Infirmities*

Environmental and genetic causes combine to cause mental infirmities. Environmental conditions would be improved if minimum standards were introduced, social security attained and educational standards raised. The genetic causes will then be brought into greater prominence. Attention is drawn to an important conclusion of the Wood Report (1929) that families containing cases of primary amentia present multiple social problems and are an important seed-bed of mental aberrations. It is recommended that further information as to this 'social problem group' be obtained through the central registers discussed in the White Paper on Social Insurance (pp. 102–108).

Chapter XV.—*Miscellaneous*

1. *Records.*

Psychiatric clinics vary much in the care with which they keep records. Requirements are reviewed as they affect four types of psychiatric clinic graded in an ascending order of complexity (pp. 109–113).

2. *The Psychiatric Clinic and the General Practitioner.*

Relations have not always been harmonious. It should be the aim of the clinic to send patients back to their doctors in an improved condition as soon as reasonably possible, and to provide doctors with helpful reports and recommendations. The chronic patient is discussed (pp. 113–115).

3. *Education in mental health.*

The activities in this direction of the Mental Treatment Department, Portsmouth, are discussed, and suggestions are made as to how the Medical Officer of Mental Health might co-operate with voluntary bodies in organizing lectures and other educational work bearing on mental health (pp. 115–118).

4. *Changes in the law : Certification.*

The need for a Consolidated Mental Health Act is outlined, and the widely advocated principle of postponing formal certification for six months after admission to a mental hospital is discussed (pp. 118–120).

5. *Regional Disparities and Minimum Standards : Planning and Voluntary Effort.*

The need for planning is considered in relation to the provision of minimum standards to overcome regional disparities. Various forms of planning are reviewed in their bearings on the work of voluntary organizations (pp. 120–125).

PART THREE

POST-WAR PSYCHIATRIC SERVICES : SHORT-TERM CONSIDERATIONS

Chapter XVI.—*The Post-War Transitional Period*

The peculiar features are reviewed of the period which will intervene between the first mitigation of hostilities and the final attainment of peace. These short-term needs should be met by measures which would, at the same time, lay the foundations of a long-term organization of the psychiatric services, especially of the Teaching Psychiatric Units. The establishment is advocated of Interim Post-graduate Psychiatric Teaching Centres whose object would be to provide, for psychiatrists demobilized from the Forces and others, training in a comprehensive social psychiatry, which would include diverse extra-mural activities. The position as to training facilities for accessory services requires immediate attention. New out-patient clinics might be started, particularly by those Mental Hospitals which have not established any. Outstanding questions relating to the recruitment, training and registration of mental nurses should be settled (pp. 125–131).

PART FOUR

FINDINGS OF THE SURVEY

Chapter XVII.—*A summary will be found on pages* 9 *to* 13.

RECOMMENDATIONS

In Part II certain innovations and various developments of existing services are advocated: these are not readily expressible as specific recommendations.

The following are the most concrete of the suggestions put forward in the report:

(I) Steps which should be taken forthwith.

1. Attention should be given to the number, location, courses and teaching staff of Interim Post-Graduate Psychiatric Teaching Centres (pp. 128–129).

2. A committee should be formed to prepare for the consideration of University Departments a basic syllabus for use at these centres (p. 129).

3. An approach should be made to Visiting and other relevant Committees of Local Authorities and to Superintendents with a view to ascertaining how many psychiatrists now in the Mental Hospitals Services would like, and be permitted, to avail themselves of facilities for post-graduate study in extra-mural work (pp. 129–130).

4. A similar approach should be made to psychiatrists in the Forces and in the E.M.S. (p. 129).

5. The training facilities for accessory services should be investigated by an officially appointed committee with a view to increasing the number of adequately trained personnel (p. 130).

6. New out-patient clinics should be started particularly by those Mental Hospitals which have not yet established any (p. 131).

7. Outstanding questions relating to the recruitment, training and registration of mental nurses should be settled (p. 46).

8. The establishment of Teaching Psychiatric Units in University Medical Schools should be actively encouraged as the essential preliminary to the training of more and better psychiatrists (pp. 42–45).

9. The neurosis survey has produced incomplete figures for four years, of which the last was 1942. No comparable data are available for later years, so that there is no means of knowing if the trends here described have been continued or reversed.

A system should be devised according to which, as a matter of routine, all psychiatric clinics tabulate their figures annually so as to admit of the central compilation and analysis of data which are complete for the whole country. Only in this way can trends be noted and developments properly assessed (p. 131).

(II) Proposals applicable to a Population of a Million (Chapter XI).

1. *In-patients.* A hundred beds per million population should, for a start, be provided outside Mental Hospitals for psychiatric cases, either in Teaching Psychiatric Units which form part of Teaching

Hospitals of University Medical Schools, or in non-teaching units located in key towns. Over and above this provision, additional psychiatric beds should be made available in whatever ways are deemed appropriate in view of local conditions and impending changes in the Poor Law, for cases now admitted into observation wards (pp. 62–69).

2. Provision for *out-patient work* can be expanded in three ways: by increasing the staff at existing sessions; by increasing the number of sessions of existing clinics; by increasing the number of clinics of an area. In view of the diversity of conditions in different areas, it is impossible to devise a formula in terms of numbers of sessions, doctor-sessions and clinics, expressing what provision is universally desirable. The necessary solutions should be found by separate areas in the light of their special features. Authorities should be prepared to increase their existing provision, in whatever ways are most appropriate, by about 75 to 100 per cent in the course of the next five years (pp. 69–73).

3. *Child Guidance Centres* should be established by Education Authorities at the minimum rate of one for every 20,000 children. On this scale, ten child guidance centres would be needed for the 200,000 children which would be comprised in a population of a million (pp. 73–74).

4. Three or four *Child Psychiatric Clinics* per million population should each form part of a central psychiatric clinic under the Mental Health Services (pp. 74–76).

5. A *hostel* for about fifty unstable or difficult children should be provided in close association with the most active child psychiatric clinic (pp. 76–77).

6. A *children's reception centre* for the sorting and appropriate disposal of homeless or destitute children, or for children needing immediate care, should likewise be established in connection with an active child psychiatric clinic (pp. 77–80).

7. Accommodation in *Mental Hospitals* should be suited to needs, and staffs increased (pp. 80–82).

8. Colonies for *mental defectives* should be provided on an adequate scale (pp. 82–84).

Provision should be made for some 4000 persons who will need community care (pp. 84–85).

9. It is further recommended that, wherever possible, the appointment system be introduced for out-patients and so arranged that no doctor-session lasts longer than three hours (pp. 72–73.)

(III) Further Recommendations.

1. Difficulties in the recruitment and training of mental nurses call for immediate attention (p. 46).

2. The Central Registers discussed in the White Paper on Social Insurance should be used to provide further information about the Social Problem Group (pp. 105–106).

3. Organizations concerned with psychiatry should consider the provisions which they would like to see embodied in a Consolidated Mental Health Act. Such an Act would incorporate the essential

principles of the Lunacy, Mental Deficiency and Mental Treatment Acts, together with such new provisions as are demanded by recent and impending developments in the education and health services (pp. 118–120).

4. The needs of children are treated in this report as having first priority in a psychiatric service which aspires to being preventive as well as diagnostic and therapeutic. Expansion and differentiation (into child guidance centres and child psychiatric clinics) of the mental health services for children are advocated (pp. 47–54).

5. The Mental Hospital Services should offer *part-time* appointments of all grades, these appointments being proportionately as well paid as full-time appointments of different levels up to the highest. The Mental Hospital Service would then be in a better position to attract doctors with keen clinical and research interests and to establish close connections with the Voluntary Hospitals. Thus strengthened, the Mental Hospital Services would undertake diverse extra-mural activities which should include a comprehensive out-patient service for adults with diagnostic, therapeutic and consultative functions; child psychiatry; forensic, criminal and industrial psychiatry; rehabilitation. Through such extra-mural services, the Mental would establish close links with the Voluntary Hospitals: central (out-patient) clinics should be located in Voluntary Hospitals, and the Mental and Voluntary Hospitals should have staff in common. The Mental Hospital Service should then be called a Mental Health Service (pp. 55–61).

INTRODUCTION

CHAPTER I

ORIGINS, HISTORY, OBJECTS AND SCOPE OF NEUROSIS SURVEY

1. Origin of Survey.

The survey described in this volume had its origin in a memorandum submitted on 4th March 1942 by Dr. Aubrey Lewis, Clinical Director of the Maudsley Hospital, to the Director-General of the Emergency Medical Services. Briefly, the argument of this memorandum was as follows:

The war had intensified the psychiatric needs of the civilian population and at the same time had curtailed the medical services by which these needs could be met. Despite the fact that surprisingly few cases of overt neurosis had resulted from the air attacks on our large cities, there were indirect reasons for thinking that psychiatric stresses were increasingly felt.

The impact of these stresses was most noticeable in industry. Absenteeism caused by neurotic illness was considerable, especially among women workers; in one industrial concern more than three times as many work-days per man were lost in 1941–42 owing to neurosis than had been lost in a pre-war year; in another firm the proportion of days lost per employee because of nervous illness to days lost through all forms of illness, had doubled; much nervous illness had been found in a special investigation of transport workers and their wives. As the war proceeded, moreover, the civilian population was becoming a dumping-ground for Service rejects. Every twelve months there were discharged from the Army some twelve thousand neurotics in Category E.

At the same time, the psychiatric services available to the civilian population had been substantially reduced because of the requirements of the Forces, especially the Army. But the Army in Great Britain contained many fewer people than the civilian population; and the Army had purged itself of many of its neurotics who had become civilians.

An investigation of the extent of neurosis and allied states, and of the facilities for consultation and rehabilitation, was called for; this should be jointly directed by the Ministry of Health and the Medical Research Council. These were the main points of Dr. Lewis's memorandum.

2. History of Survey.

The plea for an investigation was supported by the Consultant in Psychiatry to the Emergency Medical Services (E.M.S.), Dr. Bernard Hart, and accepted by the Director-General of these Services.

A committee was formed to consider how the inquiry should be conducted; the Ministries of Labour and of Supply were informed, and assistance was promised by their representatives. It was decided to base the survey on the eleven Civil Defence Regions of England and Wales. These regions (whose demarcations are shown on a map in Appendix V and whose constituent counties and areas are given in Appendix II) were primarily drawn for defence against invasion and not for a permanent establishment of medical services. Nevertheless, they presented convenient geographical areas for the purposes of a survey, each having a centralized medical organization.

Regional investigators were appointed, three to each region, representing the E.M.S., the Board of Control and the Army. Their names are given in Appendix IV. I was seconded from the Army to co-ordinate the survey from the Ministry of Health, where I began work on 21st October 1942. A questionnaire was prepared, for use by psychiatric clinics; it passed through several drafts and was finally sent out in the required numbers to the regional investigators on 3rd February 1943. The questionnaires were accompanied by a small booklet of covering instructions and notes. Analysis forms were also circulated, designed to facilitate the heavy work asked of psychiatric clinics—the analysis of records for the years 1938, 1940, 1941 and 1942. The questionnaire is shown in reduced form in Appendix I.

The tasks of the regional investigators were much eased by the kindness of Sir Laurence Brock, Chairman of the Board of Control. He released two of the Board's inspectors, Miss Catherine Gavin and Miss Isobel Laird, who greatly helped with the surveys of Regions V (London) and X respectively. The services of Miss Dorothy Thomas, made available by the Superintendent and Committee of the Cefn Coed Hospital, Swansea, were also much appreciated by the investigators of Region VIII (Wales). The Provisional National Council or Mental Health (then called the Mental Health Emergency Committee) gave valued assistance by lending their Regional Representatives. The detailed knowledge of their regions shown by the following was a strength to the survey: Mrs. D. Hardcastle (Regions III and IV), Miss E. M. Findlay (Region VI), Miss H. E. Howarth (Region VII), Miss L. Shaw and Miss E. C. Selley (Region IX) and Miss R. Addis (Region XII). To all these ladies a debt is owed.

The surveys of the regional investigators took longer than was expected. The first report was received on 3rd May, the last on 15th November 1943. In the course of that year I visited several of the regions and paid visits to a number of factories the names of whose Medical Officers had been kindly provided by the Ministries of Labour and Supply. Contact was also made with the majority of H.M. Medical Inspectors of Factories. A report on these visits will be found in Chapter V.

3. Objects and Scope of Survey.

As first proposed, the survey was intended to provide information on:
(1) The psychiatric out-patient services of the country with a view

to such reorganization and redistribution of personnel as seemed desirable in the light of changes brought about by the war; and

(2) The psychiatric reactions of the civil population to the war. Had there been an increase in neurosis? Were the out-patient psychiatric services adequate?

At this stage, recommendations for the post-war period were not envisaged. But at the beginning of December 1942 the Beveridge Report was published, which recommended that complete medical and rehabilitation services be provided free for everyone. It was realized that the survey might well serve a wider purpose than had been originally intended, and that the results might have a bearing on problems of post-war policy. The survey's scope was accordingly enlarged, and the views of the regional investigators as well as of the Directors of psychiatric clinics were sought as to how the psychiatric services of the country might be improved after the war.

The problem presented by children was considered. After some deliberation, it was decided not to include in the survey a review of child guidance clinics. The diagnostic criteria which have now been standardized for these clinics are necessarily less precise than those used in clinical psychiatry; the child guidance movement is of such recent growth that no trustworthy information would be available as to trends connected with the war; and the distribution of these clinics in the country follows no scheme or plan, depending mainly on fortuitous circumstances such as the attitudes of local education committees. The inclusion in the survey of material from these clinics would have added greatly to the labours of the investigators, and would have yielded few valid conclusions which are not already apparent to those in touch with the child guidance movement.

Questions on beds for psychiatric cases in general hospitals were not included in the questionnaire, nor were regional investigators asked to concern themselves with the matter. This information was being sought by the Survey of Hospital Services undertaken by the Nuffield Trust and by the Minister of Health.

The accommodation available during war-time in Mental Hospitals and Certified Institutions did not enter into the survey.

PART ONE

THE SURVEY: MAIN FINDINGS AND THEIR INTERPRETATION

CHAPTER II

PRELIMINARY NOTES: CIRCUMSTANCES AFFECTING THE SURVEY: PRESENTATION OF FINDINGS

1. Questionnaire used in the Survey.

It will be seen (Appendix I) that the questionnaire was divided into four parts, of which the first and fourth were printed on separate sheets. In most of the regions, the Directors of psychiatric clinics were, at an early stage of the inquiry, visited either by a member of the 'triumvirate' of investigators,[1] or by a representative of the triumvirate, *i.e.* one of the inspectors of the Board of Control specially released for the purpose, or by a regional representative of the Provisional National Council for Mental Health, or (in Wales) by Miss Dorothy Thomas. By this visitor, the objects of the survey were outlined and the questionnaire explained.

A glance at Appendix I will show that Part I of the questionnaire deals with the organization of the clinic, its staff, its accessory services and its sessions. These questions can be answered by the Director out of his head. He will have no need to consult case-material. Part IV is designed to give the Director of the clinic an opportunity of expressing his views on the clinic's needs and on other matters of general interest which may not have been raised in the first three parts. Parts II and III call for figures which require to be extracted from the clinic's case-sheets. Part II deals with routine activities not especially connected with the war, such as out-patient attendances, in-patient admissions arranged by the clinic, certain diagnoses, the sources and the disposal of patients. Part III is concerned with problems raised by the war, namely, psychiatric air-raid casualties and discharges from the Fighting Services.

This arrangement of the questionnaire made it possible for clinics which could not find time and staff to go through their case-material, to provide with the minimum of effort answers to certain essential questions. The information asked for in Parts I and IV could be elicited in a quarter of an hour's talk with the Director upon whom would be imposed no additional obligations, responsibilities or burdens.

One of the objects of the questionnaire was to throw light on changes in the mental health services introduced by the war. The year 1939 was both a war and a peace year, and therefore typified

[1] See Appendix IV.

neither condition; hence it was omitted from the questionnaire, which asks for particulars of the four years 1938, 1940, 1941 and 1942.

The questions which presented greatest difficulties were those relating to sources and disposal. These yielded information of interest, but the results did not lend themselves to tabulation.

2. Large-Town, Small-Town and London Clinics.

At an early stage of the inquiry, a *pro-forma* scheme of the tables, wherein the main findings of the survey would be set out, was shown to Professor Major Greenwood and Dr. Lewis Faning. These stressed the importance of dividing the material in terms of Local Government Administrative areas. They suggested that psychiatric clinics be separated into three groups in accordance with whether they were located in: (i) County Boroughs; (ii) Municipal Boroughs or Urban Districts; and (iii) Rural Districts. But it was later found that only two of the 216 clinics covered by the survey were located in Rural Districts—namely those at Freshwater in the Isle of Wight (Region VI), and at the Three Counties Mental Hospital at Arlesey in Bedfordshire (Region IV). Of these, the former had submitted no figures (Parts I and IV of the questionnaire only having been filled in), and the latter, the clinic at Arlesey, had recently been established as a result of a move from Hitchin, an Urban District, in 1940.

Thus it was not worth while to make a separate statistical group of clinics situated in Rural Districts. The material has therefore been divided into three different categories which, in most of the tables in Part IV, are shown separately. These categories consists of: (A) clinics located in County Boroughs outside the London Region in England and Wales (these clinics are referred to in the text as 'A' type or 'large-town clinics'); (B) clinics situated in the Administrative Counties outside the London Region—namely, in Municipal Boroughs, Urban and Rural Districts (these clinics are referred to in the text as 'B' type or 'small-town clinics'); and (C) clinics in the London Region (V). The London Region has a larger population than any other, and shows very special features which are best brought out if it is treated as a separate entity.

Important differences were revealed between these three groups of clinics which have fully substantiated Dr. Lewis Faning's contention that they should be treated separately.

3. London Region.

The London Region (V) has complex boundaries. It is roughly coterminous with the *urban* areas of what is understood in the Registrar-General's reports by the term 'Greater London'. It includes, therefore, all the Metropolitan Boroughs, the County Boroughs of Croydon, East Ham and West Ham, the whole of Middlesex and those portions of Essex, Hertfordshire, Kent and Surrey which lie within approximately a fifteen-mile radius of Charing Cross.[1]

[1] See Appendix II.

The London Region has unique features which distinguish it from all the other regions in England and Wales. Of these, the three most important are : (i) its small geographical size combined with its large population (over seven million[1]) ; (ii) its excellent facilities for transport and communication which enable a patient living in any part of the Region to attend, as an out-patient, a psychiatric clinic at one of the big hospitals in the metropolis ; and (iii) its numerous big voluntary teaching hospitals with active psychiatric departments attended by numerous patients. In London there is, among doctors and the general population, a higher degree than elsewhere of what I have called below 'psychiatric awareness'. Psychiatric problems are better appreciated and psychiatric services better recognized. It will be seen below that the 'small-town clinics' in administrative counties outside London show certain important differences from the 'large-town clinics' in County Boroughs : these differences are still more pronounced between the 'small-town clinics' and clinics in the London Region, which are the most active in the country.

Many London hospitals have been partially evacuated into the surrounding sectors ; several have sustained damage from bombs ; and all are short of staff compared with pre-war standards. Lest by asking for too much they should get nothing, the investigators for the London Region restricted the scope of their survey. Figures as to patients (Part II of the questionnaire) were asked for the year 1942 only, the years 1938, 1940 and 1941 being omitted ; and it was suggested that figures relating to air-raid casualties (Question 17, Tables VIII and IX of the questionnaire) also be omitted.

4. Partially filled Questionnaires.

If all psychiatric clinics had answered all the questions contained in the questionnaire, as did the clinics in Region VIII (Wales), the task of analysis would have been much simplified. What in fact happened was that some clinics found themselves unable to deal with the questionnaire at all ; some clinics filled in Parts I and IV only, giving no figures as to attendances ; some clinics answered part or all of Question 12 [2] about attendances, but did not answer some or all of questions about the following : admissions to hospital (Q. 13), diagnosis and incidence of neurosis and psychosis (Q. 14), disposal of psychiatric cases associated with air raids (Q. 17, Table VIII of questionnaire), incidence of direct physical injury sustained in air raids in relation to previous record of psychiatric disability (Q. 17, Table IX), and discharges from the Forces (Q. 18).

Tables are given in Part IV dealing with admissions to hospital, incidence of neurosis and psychosis, casualties associated with air raids, and discharges from the Forces. In these tables percentages are given of the patients concerned under these headings, among new patients seen in the relevant clinic-years. (This expression is explained in Part IV (10), p. 145.) If all questions had been fully answered by all clinics, the total number of new patients, of which

[1] See Appendix III. [2] See Appendix I.

various percentages are shown, would not have varied ; it would have remained the same in relation to all the groups distinguished within it. In the measure, however, that the questions mentioned in the preceding paragraph were unequally answered, so did the totals of 'relevant new patients' need to be worked out separately for each question. If, for instance, the psychiatric clinics in a given region recorded figures of new patients for fifty clinic-years, but only gave the admissions to hospital for forty of these clinic-years, attention should be limited, in calculating the percentage of admissions to hospital among total new patients, to the new patients seen *in these forty clinic-years*. The worse a given question is answered by the clinics in a region, the smaller becomes the total of ' relevant new patients ' of which percentages are calculated. In the comments on the tables in Part IV, attention is drawn, where necessary, to the number of clinic-years for which information is available ; and reference is made, for purposes of brevity, to ' known ' clinics when what is meant is ' clinics which have provided the relevant information '.

The fact that the ' known ' clinics fall short of the total number of 216 clinics unavoidably diminishes the validity of general conclusions based on the available figures. The wider the gap between total and ' known ' clinics, the less are the conclusions to be regarded as generally valid.

5. Number of Clinics included in Survey.

Two hundred and sixteen clinics are recorded which are listed according to their regions in Appendix V. Certain difficulties have arisen about this number as a result of the following circumstances :

(i) A few clinics were closed during the war either owing to small attendances or because of shortages of staff. These clinics gave figures for less than the four years covered by the survey ; but since they were active when the war started and intend to resume activity when it ends, they have been included in the tables. So have clinics opened after 1938.

(ii) The staffs of two separate Mental Hospitals sometimes held sessions on different days of the week, in the same premises, in a Voluntary or Municipal Hospital. Thus the staff of the Borough Mental Hospital might see ' city patients ' on one day, and the staff of the County Mental Hospital might see ' county patients ' in the same place on another day. The records are usually kept apart and separate questionnaires were filled in by the two mental hospitals. Two clinics were here counted, the number corresponding with the questionnaires sent in, and not with the geographical location.

(iii) The converse of the above occurred in some regions. That is to say that the staff of a given mental hospital held sessions weekly or less often in different centres in their area. Either because of small attendances or because the records were not kept separately, a single questionnaire was used to provide returns for multiple clinics. In such cases the clinics were, when possible, separately counted if they

dealt with adults, though the records were pooled and therefore unassignable to the separate clinics.

6. Case-Sheets in use at Clinics.

There is no uniformity in the type of case-sheet or record-card used in the psychiatric clinics of the country. Directors of clinics were requested to send in a specimen copy of their case-sheets. Some of these were elaborately drawn up, and contained many headings. Others had no headings; use was made of a blank sheet of paper. In a few clinics, according to the regional investigators, the psychiatrist made notes on any piece of paper handy, telephoned his report at the end of the session to the practitioner who had sent the patient, and then tore up the notes. Such clinics had no records and were unable to fill in Parts II and III of the questionnaire.

7. Statistical Significance.

Various statistical methods have been applied throughout the analysis to test the validity of the deductions made. Since to the ordinary non-statistical reader details of these tests would be meaningless, they are not reproduced. But the standard errors of all differences are tabulated since the majority of medical readers are to-day familiar with their purport.

Throughout this report the criterion of significance adopted is that of twice the standard error. A difference, to be 'real' (that is, unlikely to have arisen by chance), must exceed twice its standard error, which implies that such a difference would occur by chance only five times in a hundred trials.

So far as the comparisons between the three main types of clinics are concerned (large-town, small-town and the London clinics), all the differences are statistically significant unless otherwise stated. Such tests were more difficult to make between the eleven regions. Owing to the smallness of the numbers involved, to wide variability within each region and to individual differences in completing the questionnaires, statistical comparisons between regions were unsatisfactory, and should be accepted with due reserve.

CHAPTER III

MAIN FINDINGS SUMMARIZED

THE findings of the survey are shown in a series of tables in Part IV of this report.

A summary of these tables is here given. The numerical headings correspond with those in Part IV, which should be referred to for further information.

1. The Eleven Civil Defence Regions: their Boundaries, Populations and Investigators are described (pp. 132–133). See also Appendices II, III and IV.

2. How the Questionnaire was filled in.

Psychiatric clinics, on the whole, and in view of war-time difficulties, co-operated well in the survey. Of 216 clinics, 186 (86·1 per cent) responded to the questionnaire, and 145 (67·1 per cent) filled in all the parts asked for (p. 133).

3. Psychiatric Clinics and Population.

The survey revealed considerable *inequalities in the distribution of out-patient facilities throughout the country.* In England and Wales as a whole there were 5·47 psychiatric clinics per million of population; but the figures ranged between 3·66 clinics per million in Region X and 9·14 in Region XII. The south of England was better served than the north; the aggregate number of clinics per million in the two regions in the north (I and X) was 3·74; the corresponding figure for the three regions which form the south coast (VI, VII and XII) was 7·75 (p. 134).

4. Status and Staffing Arrangements.

Of 210 clinics giving the necessary information, 149 (71 per cent) were located in Voluntary Hospitals; 30 (14·3 per cent) in Municipal Hospitals; 15 (7·1 per cent) within the curtilage of Mental Hospitals; and 16 (7·6 per cent) in places other than hospitals (pp. 134–136).

The large proportion of clinics established in Voluntary Hospitals, more than two-thirds of which were staffed by psychiatrists based on Mental Hospitals, provides a satisfactory example of co-operation between Voluntary Hospitals and Local Authorities.

5. Dates of Establishment of Psychiatric Clinics.

The Mental Treatment Act (1930) provided an important stimulus to the establishment of psychiatric out-patient clinics. Of 177 clinics

giving the relevant information, 148 (83·1 per cent) were established after 1929. The growth of out-patient services has thus been recent and rapid (pp. 136–137).

6. Activity of Clinics.

The activity of a psychiatric clinic can be measured in several ways, among which may be counted the frequency of its sessions and the number of doctors attending each session (the product of these two giving doctor-sessions); also by the total number of patients seen in a year, and by the number attending each clinic- and doctor-session; also by the ratio between first and return attendances. The average number of doctor-sessions per week for 189 clinics was 2·42; but the figure differs much between the three types of clinics mentioned on page 5. For clinics in the London Region in 1942 the average number of doctor-sessions per week was 4·96, for clinics in County Boroughs outside London it was 2·05, and for those in Administrative Counties it was 1·42. Weekly doctor-sessions per million of population —a valuable comparative index of the activity of different areas—also show wide regional variations ranging from a figure of 26·7 for the London Region (an underestimate) to 4·94 for Wales (pp. 137–141).

7. Accessory Services.

Psychiatric clinics were on the whole inadequately equipped with accessory services. Of 192 clinics giving the relevant information, 66 (34·4 per cent) made use of psychiatric social workers, 67 (34·9 per cent) of social workers or almoners, and 20 (10·4 per cent) of psychologists. None of the 'known' clinics in Regions I, II, VIII, IX or X used a psychologist; and clinics in the south had more accessory services than those in the north-east. Thus, of psychiatric social workers and almoners taken together, each of Regions VI, VII and XII, which form the south coast, averaged over thirteen; while Regions I and II (Northumberland, Durham and Yorkshire) had nine between them (pp. 141–143).

8. Reception of Children.

Arrangements for the reception of children were not significantly different in the three groups of clinics, though they may have been affected in the large towns by the growth in the number of Child Guidance Clinics. Psychiatric clinics in the London Region may have differentiated their functions more than those elsewhere to meet the needs of children (pp. 143–144).

9. Pressure on Psychiatric Clinics.

Of 190 clinics which supplied information, just under three-quarters (74·2 per cent) had not experienced pressure during the period covered by the survey. Clinics in the London area, however, had experienced more pressure than clinics elsewhere; only 56·6 per cent had not experienced pressure (pp. 144–145).

10. Clinic-Years.

Attendances of patients are considered in terms of clinic-years. A clinic giving figures of attendances for each of the four years included in the survey, covers four clinic-years. Figures showing attendances are available for 491 out of 682 'possible' clinic-years (72 per cent). Clinics in the London Region gave figures for 1942 only. The data for the three groups of clinics are generally comparable (pp. 145–146).

11. New Patients.

During the 491 clinic-years for which figures of new patients are available, 51,601 new patients were seen—an average of 105·1 new patients per clinic-year. The average figure for large-town clinics (114·1) was more than twice as large as that for small-town (51·8)—a striking difference. The figure for London clinics in 1942 (an average of 372 new patients) is more than three times larger than the figure for large-town clinics averaged for the four years (114·1)—again a striking difference. More new patients were seen in 1942 than in 1938; the increase at small-town clinics was especially noteworthy, the averages being 40·3 new patients in 1938 and 71·9 in 1942. This is an encouraging sign which points to the active development of the small-town clinics in the face of war handicaps. There were conspicuous variations between regions.

Generally, similar results are shown during 416 clinic-years by 104 clinics outside London which gave figures for all the four years.

Of 158 clinics giving the required information, 101 (63·9 per cent) received less than two new patients per clinic-session—figures which do not suggest a high degree of pressure. The percentage of London clinics in 1942 which received under two new patients per session (22·9 per cent) is conspicuously smaller than that of large-town clinics (70·3 per cent) and of small (81·4 per cent), again suggesting that the London clinics are the most active and the small-town clinics the least. Figures for average attendances at doctor-sessions show similar group differences, though their interpretation is not so simple.

If in 1942 the activity of provincial clinics (judged in terms of new attendances per population) had been raised to that of London clinics, between twice and thrice as many new patients would have been seen in the country as a whole. But caution is needed in interpreting such estimates (pp. 146–152).

12. First and Return Attendances.

The activity of a clinic can also be estimated by comparing the number of first attendances (new patients) with that of total attendances comprising first and return attendances. The London clinics have most return attendances and the small-town clinics least (pp. 153–155).

13. Admissions to Hospital.

Admissions to hospital are shown as percentages of new patients.

Of 37,756 new patients, as to whom relevant information is available, 7283 (19·3 per cent) were admitted to hospital. The admissions of Temporary and Certified patients are lowest from clinics in the London area and highest from small-town clinics. The differences are probably accounted for by the fact that the London clinics see a higher proportion of mild cases, including neurotics, who do not require certification, than do clinics outside London. Throughout the four years the percentage of Temporary and Certified cases admitted to hospital has steadily declined, which again suggests that mild and early cases have been increasingly dealt with (pp. 155–159).

14. Incidence of Neurosis and Psychosis.

It was possible to classify 45,201 new patients in terms of diagnosis, of which three categories were separated—neurosis, psychosis and 'other'. The London clinics dealt, in 1942, with the largest proportion of neurotics and the smallest of psychotics, and the small-town clinics with the smallest proportion of neurotics and the largest of psychotics. Figures of clinics outside London for 1942, when compared with those for 1938, show a rise in the proportion of neurotics and a fall in those for psychotics. This again suggests that clinics were increasingly dealing with mild or early cases—a satisfactory development for which the small-town clinics deserve credit (pp. 159–163).

An estimate (to be taken with caution) is submitted that if provincial clinics had dealt in 1942 with as many new neurotic cases per population as were received by the active London clinics, new cases of neurosis seen at all the clinics in the country would have been more than twice as numerous as they actually were.

15. Psychiatric Air-Raid Casualties.

In view of the total physical casualties caused by air raids and of the stresses which they caused, it is remarkable that, in only about one case in thirty was the patient's disability connected by the psychiatrist with air-raid experiences. A larger proportion of these cases was seen at small-town clinics than large. The difference is not easy to explain; it may be attributable to the small-town clinics dealing with timid and neurosis-prone persons who left the large centres of population when these became targets of air attacks. About one in five of these psychiatric casualties was admitted to hospital. About one in five also sustained physical injury, and the percentage of these cases among total psychiatric air-raid casualties was smaller in small- than in large-town clinics. About one in three cases had a previous history of psychiatric disability, and the proportion of these who suffered physical injury was smaller than of patients without a previous history—a finding which is in accordance with expectation (pp. 164–170).

16. Discharges from the Fighting Services.

Of 41,982 new patients as to whom relevant information is available, 1056 (2·52 per cent) were discharged from the Fighting Services. Clinics in the London area dealt proportionally with the largest number (4·93 per cent) of these discharged patients and the small-town clinics with the smallest. This difference is probably due to the good transport facilities in London, which made the clinics accessible, and to the fact that the London clinics are known to cater for neurotics, which comprised 68·5 per cent of psychiatric discharges from the Forces. Proportionally most cases in the category which comprised psychosis were dealt with at small-town clinics and fewest at clinics in the London area (pp. 170–174).

17. Developments advocated by Directors of Clinics.

Directors of psychiatric clinics were asked what developments of services they considered desirable. Seven were listed. The answers showed that the two major deficiencies, as judged by the Directors, are the shortage of in-patient facilities and shortages of staff. The more active the clinic, the greater the awareness of deficiencies and the expressed need for developments (pp. 174–175).

18. Latent Neurosis.

A majority (57·5 per cent) of the Directors of clinics who expressed definite views on the subject held that there existed in the civilian population latent neurosis likely to disclose itself after the war (pp. 175–176).

19. 'M' and 'O' Clinics.

Psychiatric clinics staffed by psychiatrists based on mental hospitals ('M' group) are compared with those otherwise staffed ('O' group). The results show that the 'M' group clinics, taken as a whole, were established later; they were less well equipped with social workers, almoners, psychologists [1] and speech therapists, but better equipped with psychiatric social workers; [1] they held less frequent clinic- [1] and doctor-sessions; they dealt with fewer new patients per year and with fewer at the average clinic- and doctor-sessions; they saw fewer return cases; and they dealt with a smaller proportion of neurotics and a larger one of psychotics. These results are not to be counted in disparagement of the work done by psychiatrists based on Mental Hospitals. On the contrary, these deserve every credit for the recent and rapid development of the country's psychiatric out-patient services for which they are mainly responsible [2] (pp. 176–183).

[1] Differences not quite significant. [2] See page 21.

CHAPTER IV

QUESTIONS ARISING FROM THE FINDINGS

1. Has there been a Real Increase of Neurosis ?

The findings described in the preceding section raise important questions, some of which will now be considered.

An increase in the numbers and proportions of cases of neurosis has been noted in the years 1941 and 1942 when compared with 1938 and 1940 ; was this increase caused by the war ?

This question cannot be answered without examining the possible causes of increased attendances which have no connection with the war.

What, we may ask ourselves, is the main cause of a rise in attendances over a given period at any single psychiatric clinic ? There is no doubt as to the main cause. It is the attitude towards the clinic of the general practitioners working in the area served by the clinic and the proportions of the total number of practitioners in the area who use it. These proportions vary throughout the country. The investigators of Region II (West Riding of Yorkshire) report that, of the practitioners in a town in that region, some 15 per cent only had ever referred patients to the psychiatric clinics of that town. The attitude to the clinic of the practitioner depends much upon the service which the clinic gives him, and upon the reports on the clinic which his patients bring back. Let us consider two contrasting possibilities.

A practitioner is confronted with what is for him a difficult ' psychological ' case. He has heard of the existence of a psychiatric clinic in the neighbourhood, and sends the patient up with a letter. Later, the patient returns with an unfavourable report on the clinic. She was kept waiting for two hours in a draughty, ill-lit and forbidding room ; she was then interviewed by a doctor who seemed to be in a hurry, asked her a lot of peculiar questions, did not examine her physically and prescribed a bottle of medicine for which she had to wait another hour. In due course the practitioner receives a short letter saying that the patient is suffering from an anxiety state with features of depression, and that the possibility of schizophrenia must be borne in mind. He finds the letter quite unhelpful and the patient is no better for her visit to the clinic, to which she has no desire to return. The practitioner is not encouraged to follow up the experiment.

On the other hand, the patient may return with praises of the clinic. She was welcomed and made to feel at home in a comfortable room where she was not kept waiting long ; the doctor took a lot of trouble and seemed to understand her case and set her mind at rest about some of her worries, etc. Later, the practitioner receives a full letter giving him useful guidance as to how to handle and treat the

patient who, it is suggested, should attend the clinic again once or twice. The patient benefits, and the practitioner is glad to avail himself of the clinic's services on future occasions.

A psychiatrist who takes trouble over his clinic patients, who succeeds in giving them confidence and who writes helpful letters to their doctors soon finds his attendances rising. In the early days of the establishment of a successful clinic, the psychiatrist usually finds that a large proportion of cases come from a small proportion of doctors in the area. But the reputation that a clinic is helpful both to patient and practitioner quickly spreads, and initially modest attendances can soon swell to unmanageable proportions, finally necessitating the institution of an appointments system. This is what was happening to many London clinics about the year 1939, when the war cut down their staffs and produced serious overcrowding. The introduction of appointment systems then led to lengthening waiting lists and later to a refusal to accept new patients; also to a demand that psychiatric services be centrally organized and rationalized.

The attitude towards the clinic of the practitioner must be taken in conjunction with another factor which is peculiar to neurotic illness; its enormous range and its vague delimitations. How much current sickness is purely psychogenic? And how much organic illness has a neurotic superstructure which can be mitigated by psychological treatment? These are questions as to which there are diverse opinions. The so-called psychosomatic disability has been much discussed of late, here and in America; it has even been suggested that as much as a third of all sickness has psychiatric features, the term psychiatric being used to include psychosomatic illness. We can picture to ourselves the effects on clinic attendances if practitioners as a whole came to believe that a third of their patients could be benefited by the attention of psychiatrists. The community contains, as it has always contained, a reservoir of psychosomatic and psychopathic cases; their descent in vast multitudes upon the psychiatric clinics of this country might be caused by nothing more than an alteration of standpoint among general practitioners.

There are reasons for thinking that changes of the sort above described have been occurring in the course of the last fifteen years. It was noted in the survey (Table V, p. 137) that eight out of ten of the known clinics in large towns and nine out of ten of those established in small towns were established after 1929. It is therefore possible that, with the increase of psychiatric clinics and the spreading recognition of their services, aggregate first attendances have been continuously rising since that date. Unfortunately, figures are not available as to the trend of these attendances between 1930 and 1938. They might well have shown a progressive rise wherein the drop noted in 1940 was but a temporary lapse. Nor is it certain that the increases observed in 1941 and 1942 would not have occurred in the absence of war.

2. Would a Real Increase of Neurosis be detectable To-day ?

A further question now arises : if there had, in fact, occurred an *actual increase* in neurosis in the country or in a part of it, would this be in any way recognizable or detectable ? The war may have produced such an effect in the last five years : or a period of economic depression may have done the same before the war. If a real increase in neurosis had occurred, are there any certain means by which it could have been recognized ?

In comparing the incidence of a disease or abnormality in a given place at two periods of time, three conditions must be satisfied if valid conclusions are to be drawn without complicated corrections : the abnormal condition must be clearly recognizable ; the social facilities for its discovery must be about the same in the two periods ; and diagnostic methods must not have undergone refinement. In an attempt to estimate the comparative prevalence at two time-periods of clear-cut diseases such as tuberculosis or syphilis, we would not take a higher incidence in the second survey at its face value if social facilities for the detection of cases had been better in that survey, and if improved methods of diagnosis—say by serological tests—had been introduced in the interval between the two investigations and used in the second.

Difficulties of comparison were considerable in a recent investigation of such a readily identifiable and diagnostically fixed condition as mental deficiency ; they were discussed at some length by the Wood Committee. Yet in their concern with mental deficiency, the Wood Committee (1929) were like men standing on firm ground ; compared with them, the investigator of neurosis is struggling in a quicksand.

Nothing could confidently be said to-day about real trends of neurosis except perhaps in reference to a circumscribed area which had been kept under continuous supervision by a competent observer who was able to make allowances for unavoidable changes in standards. Of the country as a whole, it is probably true to say that well-grounded generalizations about trends will not be possible until diagnostic and therapeutic standards are clearer and also more widely understood than they are to-day. Psychiatry is in a transitional state ; means of treating both in-patients and out-patients are likely soon to be amplified and diagnostic standards are largely uncertain. We know where we are with the text-book headings and descriptions ; but beyond these, in an ever-receding perimeter, we discern an almost uncharted no-man's-land between psychological and physical illness. There is at present little agreement on the indications for admission to hospital, which are apt to vary with the available accommodation ; or on the criteria by which therapeutic results are to be measured ; and there is still some ignorance among sections of the medical profession as to what psychiatry is and can do. Until the subject's clinical frontiers are more generally recognized, until uniform standards are adopted of severity of illness, of degrees of recovery and of cure ; and until the means of treatment, both of in- and out-patient, are unified through-

out the country, there will be little hope of measuring real trends in the prevalence of neurosis, except in circumscribed areas where the practitioners are known and where clinic attendances in different years can be assessed in the light of all relevant factors. These considerations afford the best possible argument for promoting intensive inquiries of limited scope such as are now being carried out for the Industrial Health Research Board by Dr. Russel Fraser. This investigation is establishing a valuable precedent; it is providing exact material for future comparison; and it will help to formulate serviceable definitions of diagnostic categories and psychiatric terms for future surveys.

3. Dual Origins of Out-Patient Psychiatric Services.

The neurosis survey has brought into relief the dual origins of our psychiatric clinics. The oldest and most active clinics are the spontaneous creations of Voluntary Hospitals where they were the product of the hospital's internal development. Attention had been drawn in the last war to the successful treatment by psychological methods of what was then called shell-shock. Neurotic illness in its various forms came to be recognized more clearly than formerly; and an optimistic view of the possibilities of treatment was prevalent. Notice had been taken both by the medical world and the lay public of the striking reports of how victims of war neuroses had been cured by suggestion, hypnosis, catharsis and so-called analysis. Cases of neurosis were usually referred to the neurological departments of hospitals, often by the other hospital departments, but also by practitioners outside the hospital. Such patients sometimes caused embarrassment; there were few satisfactory facilities for treatment; adequate disposal was difficult and these cases were apt to become chronic hangers-on, returning again and again for their bottle of medicine, varying little their recital of symptoms and complaints, yet somehow sustained by a faith in the hospital. The predicament thus caused was frequently met by establishing a new Department of Psychiatry or of Psychological Medicine, which was frequently an offshoot of the Department of Neurology. Among the general sequence of neurotics, an occasional mental defective might be seen, or an early schizophrenic, or a patient with paranoid symptoms. But these cases were in a minority; they were often dealt with by a recommendation that they be brought to the attention of the Relieving Officer.

With the establishment of Departments of Psychiatry, facilities were created for dealing better with neurotic patients. Psychotherapy was arranged; a psychiatric social worker was often added to the staff who furnished reports on the domestic or occupational background; a psychologist frequently helped with intelligence tests. A close liaison was usually established with the Department of Paediatrics, and child guidance might be undertaken. As the Department became known to the practitioners in the neighbourhood, increasing numbers of patients were referred from outside. In the decade 1930–40 the volume of new and old patients attending

psychiatric departments of some Voluntary Hospitals was so great that, with the help of the psychiatric social worker or the almoner, an appointment system was introduced. Waiting lists then began to form, and with the passage of time, became longer. These tendencies were facilitated by the activities of voluntary societies which drew public attention to what came to be called mental hygiene and to advantages of early treatment. During the war, pressure of patients in some Voluntary Hospitals, especially those in the London Region, was aggravated by staff shortages. In some places it now presents a formidable problem.

This is the position of many large Voluntary Hospitals in big towns to-day where the clinical material seen in psychiatric departments predominantly consists of neurotics.

But with the passing of the Mental Treatment Act in 1930, another type of psychiatric clinic came into being. This Act rendered possible the admission to a Mental Hospital of the Voluntary patient. And it gave power to Local Authorities to make arrangements for providing out-patient treatment for psychiatric cases in their areas. The clinics thus established were almost always staffed by psychiatrists based on one of the Mental Hospitals, and were located in what was deemed the most convenient place. An arrangement was often reached with a Voluntary Hospital whereby sessions were held in its building, appropriate payments being made by the Local Authority; or the clinic was located in some other accessible place, as shown in Tables III and IV (p. 135). The recent expansion of the country's psychiatric out-patient services is shown in Table V (p. 137). Eight out of ten of the known clinics in large towns outside London were established after 1930, as were nine out of ten of those in small towns.

But the clinics which originated from the Mental Treatment Act differed in important ways from the autonomous psychiatric departments of Voluntary Hospitals. Unless established in general hospitals, they received few patients from other hospital departments. And when the clinic was located in a general hospital, the liaison between the visiting psychiatrist (whose contacts with the hospital were limited to his weekly or bi-weekly attendances) and the rest of the hospital staff was sometimes imperfect. In some areas, the fear wherein the Mental Hospital is still held could extend to the newly established clinic; the appropriate type of patient, it was thought, to send there was not so much the neurotic who needed psychotherapy as the early psychotic who might require to be admitted to a Mental Hospital as a Voluntary patient. The clinical material included more cases of early psychosis and fewer of neurosis than that seen at a psychiatric department which formed an integral part of a Voluntary Hospital. Tables XXXVII—XLVI (pp. 176–183) show that the typical psychiatric clinic established by a Local Authority differs from the typical clinic under the sole auspices of a Voluntary Hospital in holding fewer sessions, in dealing with fewer new patients, in seeing fewer return cases, in handling a smaller proportion of neurotics and a larger of psychotics.

But there are also reasons for thinking that these differences are

becoming less pronounced with the passage of time. For it would be a grave mistake to hold the staffs of clinics established by Local Authorities as responsible for the misgivings which the newly established services sometimes evoked. Many psychiatrists on the staffs of Mental Hospitals take a keen interest in neuroses and in the development of the extra-mural side of their work. But they are handicapped, especially in the small towns, by an unawareness on the part of the general practitioners of the services which a psychiatric clinic can give, and by a superstitious fear that the clinic is in fact a portal of entry to the Mental Hospital. The questionnaires used in the survey gave opportunities to psychiatrists to put forward their views and to describe their difficulties. Many contained references to the 'backwardness' of sparsely populated districts and to the need of publicizing the services which the clinic could render.[1] Several questionnaires contain entries stressing the usefulness of the psychiatric social worker as a liaison officer; she can establish necessary contacts with doctors, public assistance officers, relieving and probation officers, teachers and others, and can make known to them the help which the clinic can give.

A comparison of the available figures for the four years covered by the survey discloses the fact that improvements are taking place in these matters (Part IV (11), p. 146). Average yearly attendances rose after 1940, the increase being most marked in the small-town clinics, of which a majority are staffed by psychiatrists based on Mental Hospitals. In these small-town clinics nearly twice as many new patients were seen in 1942 as in 1938 (Table XV, p. 146). That this is partly due to the large-scale evacuation from big towns can scarcely be doubted, and it is possible that, among those so evacuated, timid and neurosis-prone persons were well represented; but the fact remains that the annual first attendances at large-town clinics have also risen, and that some of these clinics, especially those situated in the London area, are now working to full capacity. It is also noteworthy that the proportions of neurotic cases to total patients has risen. These proportions are generally higher in large-town than in small-town clinics (Table XXV, p. 160); but they nevertheless strikingly rose in the small-town clinics from 39 per cent in 1938 to 52 per cent in 1942. That these clinics are increasingly used for the treatment of mild and early cases is an encouraging and healthy sign; and full credit must be given to the staffs of Mental Hospitals who predominantly serve these clinics. There is good reason to think that if accessory services were as generously supplied to the small-town clinics as to the large, further changes would be disclosed in the desired direction. The trends which are discernible even amid the throes and dislocations of war are finger-posts which should guide our paths in the future. The suggestions contained in Parts II and III of this report are designed to further these trends and to bring them to fruition in a harmonious and geographically uniform psychiatric service, wherein the staffs of Voluntary and Mental Hospitals assist and offset each other, working to a common plan.

[1] See page 71.

4. Central, Affiliated and Independent Clinics.

There are other differences, which it will be convenient to consider here, between the psychiatric clinic staffed by psychiatrists from Mental Hospitals and those otherwise staffed. We may now distinguish between the *Central*, the *Affiliated* and the *Independent* psychiatric clinic.

The *Central* clinic is the headquarters of a psychiatric team which visits other clinics, and provides their medical staff. This team may consist, as a minimum, of a single psychiatrist, and as a maximum of one or more psychiatrists, psychologists and psychiatric social workers.

The *Affiliated* clinic is one which is visited at fixed times—once or twice a week or less often—by a psychiatric team based on a central clinic.

The *Independent* clinic has a psychiatric staff of its own; it is not visited, as is the affiliated clinic, by a psychiatric staff whose headquarters is elsewhere; nor, like the central clinic, does its staff undertake responsibilities for affiliated clinics in other places. The active clinics of most of the big London Voluntary Hospitals are 'independent' in this sense.

These distinctions enable us to discern another important difference between the two classes of psychiatric clinic here considered—those staffed by psychiatrists based on Mental Hospitals ('M' clinics) and those otherwise staffed ('O' clinics). The difference arises from the fact that the Voluntary Hospital's responsibilities and duties do not spread over a geographical area as do those of a Local Authority. Very few psychiatric clinics in self-sufficient Voluntary Hospitals have peripatetic teams and affiliated clinics. Indeed, of the 66 'O' clinics listed in Tables XXXVII–XLVI (pp. 176–183), only two have affiliated clinics covered by the neurosis survey—those of the Maudsley and of Guy's Hospitals. The Maudsley[1] has three affiliated clinics, and Guy's has one whose activities may come to an end with the war. Of clinics, on the other hand, established by Local Authorities and staffed by psychiatrists based on Mental Hospitals—the 'M' clinics shown in the above-mentioned tables—many are 'affiliated'. Thus, of 101 Mental Hospitals, 77 have one or more affiliated clinics. The survey has shown that there are 150 clinics staffed by psychiatrists from these 77 Mental Hospitals.

It may be remarked parenthetically here that it is not always easy to determine which of these 150 'M' clinics are central and which affiliated. The psychiatrists of a Mental Hospital may provide the staff of as many as 5 clinics in different places. It would seem natural to regard the Mental Hospital itself as the headquarters of its peripatetic team and as constituting its 'central' clinic. But not all Mental Hospitals hold out-patient clinics within their curtilage. Such clinics are, in fact, held by 15 only of the 77 Mental Hospitals which conduct psychiatric clinics; and the clinic established within the Mental Hospital's curtilage may not be the largest or the most active,

[1] See footnote, page 135.

and may not therefore deserve to be called its 'central' clinic. More often it happens that one of the Mental Hospital's outside clinics, situated in the largest centre of population, is more active than the others; this clinic might more properly be designated as 'central'. But it also occurs that, of several visited clinics, none holds such a privileged position, so that it is impossible to designate one clinic as being more 'central' than the others. These difficulties of definition need not be stressed. They are to be expected in view of the recent development of the peripatetic team (which apparently hardly existed before the Mental Treatment Act was passed in 1930), and of the differences in outlook between the self-sufficient Voluntary Hospital or institution and the Local Authority. The distinction between the central, the affiliated and the independent clinic serves two purposes:

(1) It goes far to explain the differences above noted between the mostly independent 'O' clinics which are parts of self-sufficient Voluntary Hospitals or other organizations, and the 'M' clinics which are staffed by psychiatrists based on Mental Hospitals. It was remarked above that the latter held fewer sessions than the former, dealt with fewer new patients, saw fewer return cases and handled a smaller proportion of neurotics. To an appreciable though indefinable extent, these differences are due to the fact that peripatetic visits to affiliated clinics, mostly small and of recent origin, are carried out much more by psychiatrists belonging to Mental Hospitals and working in the boundaries of Local Authority areas than by psychiatrists centred in self-sufficient Voluntary Hospitals or other psychiatric institutions. Outside duties undertaken by psychiatrists in Mental Hospitals are the result of new psychiatric responsibilities undertaken in new areas. It is much to the credit of the Mental Hospitals and of the Board of Control that, in so short a time, they have opened up these new fields and shouldered new tasks on such a large scale.

(2) In the suggestions for future development which follow, the distinction between the central and the affiliated clinic is stressed. An essential feature of these suggestions is that the mental health services of the future should make full provision for the needs of children. The central psychiatric clinic will, it is hoped, concern itself closely with these needs; and it will later be suggested that, in a typical Joint Authority area, three or four central psychiatric clinics should incorporate a *child psychiatric clinic*.

The distinction between the central and affiliated clinic is in effective operation in the child guidance services which make considerable use of peripatetic teams. It is essential that the psychiatric services for adults and children be drawn closer together and combined in a general mental health service, links being at the same time established with the paediatrician. There are several reasons why such an adjustment is called for. One is that a large part of child psychiatry consists in guiding and advising the parents.

CHAPTER V

NEUROSIS IN INDUSTRY

AMONG the considerations which led to the promotion of the neurosis survey was uncertainty as to the psychiatric effects of the war on the civilian population. From the bombing of our large cities a heavy crop of psychiatric disorders had been expected. Much had been heard of such legacies of the last war as shell-shock (so-called), of conversion hysterias, of anxiety states, of traumatic neuroses and neurasthenias. It was a source of almost universal surprise that, throughout the aerial bombardments of the civilian population in 1940 and 1941, very few of these conditions materialized. Yet there were good reasons for supposing that the manifold stresses of war were having bad effects. Disquieting reports were heard from various sources, especially from the many industries concerned with war production. Absenteeism was becoming a serious problem, wherein psychological factors were clearly operative. How far, it was asked, could the limited psychiatric services remaining at the disposal of the civilian population be internally readjusted so as to mitigate these stresses? Representatives of the Ministries of Labour and Supply took part in the preliminary discussions of the neurosis survey; they gave their support and promised assistance. Lists of Industrial Medical Officers in key industries throughout the country were furnished, and the approach to these by an investigator was facilitated.

In the first six months of 1943 I made full use of these facilities. I visited a number of factories in and around the following centres of industry: London, Birmingham, Manchester, Leeds, Sheffield and Bristol. I made contact with H.M. Inspectors of Factories, representatives of mining and shipping industries and of certain large corporations, and with various insurance companies. Much help was given and co-operativeness shown, for which warm thanks are due.

This part of the survey had two main objects. They were to find out (i) if there had been an increase of neurosis in industry since the war began, and (ii) if the psychiatric services were adequate. A considerable body of miscellaneous information was obtained; but this was based on the experiences and views of persons in close contact with industrial problems rather than on precise figures susceptible of comparison and analysis. The latter, as will subsequently emerge, were impossible in the circumstances to obtain. The inquiry was attended by many unforeseen difficulties; these became apparent as it proceeded, and call for some consideration before conclusions are drawn.

Difficulties and Limitations of the Inquiry.

1. In drawing up their lists of undertakings and firms which they thought would provide relevant information, the Ministries of Labour and Supply were guided by two considerations: the selection of

representative samples from the various spheres of war work, and the submission of the names of such Industrial Medical Officers (hereafter called I.M.O.s) as were in a position to assist. Industry was therefore seen in the light of the large firm or undertaking, employing an I.M.O., rather than of the small concern with simple medical arrangements. In 1936 97·1 per cent of the Registered Factories of the country employed less than 250 persons, and of the total number of persons employed in industry, 52·7 per cent worked in these small units.

Few of such small factories have the services of full-time or even part-time I.M.O.s. To this extent the perspective of the survey was one-sided.

2. Industrial medicine, itself a part of social medicine, is undergoing a rapid evolutionary change. Indeed, there are few branches of medicine with greater potentialities of development. Wide vistas are being opened and much energy shown. Important developments have occurred since the war began. There were complaints of maldistribution. It was argued by some that the best and most experienced medical personnel was unevenly spread throughout industry; that there was little uniformity in the amount of medical supervision available in different industries or in the conditions in which I.M.O.s themselves worked. The length of time during which the interviewed I.M.O.s had spent in the posts they were then holding varied between a few weeks and thirteen years. The average was 4·3 years; and 18 out of 28 had taken up their work after the beginning of the war. Of 30 I.M.O.s 12 had available no sickness statistics; and the figures of the remainder were not all classified by diagnosis.

The methods by which sickness-absenteeism was assessed were frequently being changed and improved. New standards were being introduced and new criteria established. Valid comparisons between the sickness figures of one war year and another were by no means easily obtained. Many hoped that approved standards would be centrally drawn up for universal adoption—a step which has since been taken. Industrial risks and hazards in different undertakings and in different parts of the country could then be compared.

3. The quality of labour had undergone changes for the worse during the war. Men of military age had been called into the Forces, leaving behind the old, the very young and the infirm. As the war advanced, more women were absorbed into industry; many were transferred from one part of the country to another without receiving a preliminary medical examination in the area from which they were moved. There were many complaints of the quality of this transferred labour. The medical officer of a big concern in the North remarked to me: 'It would frighten you to see the people who are now sent to this place'. He showed me a list of Ministry of Labour Transferees whom he had recently examined—all women. Here are some of the remarks included in his report on the batch:

'Vision very poor. In low mental category and apparently unemployable.'

'Has congenital heart disease and is breathless on the slightest exertion. Entirely unfit for factory conditions and hours.'

'Has defective vision and poor physique and mentality. Quite unfit for factory employment.'

'Very defective vision and unsuitable for factory employment. Has never been out to work before.'

'Has done very little remunerative work. Poor physique, anæmic and has a weak heart. She is unsuitable for any remunerative employment.'

'Is of decidedly poor constitution and suffers from chronic bronchitis. Looks as if she may be consumptive.'

In general, sickness rates and absenteeism are higher among women than men; and long hours put a heavier strain on women, not only because of their poorer physique and stamina, but because of the time they have to spend on housework and shopping.

Another I.M.O.—of a big Midland firm with a high peace-time reputation for the quality of services accorded to its employees—distinguished between a nucleus of about 5 per cent of 'trusted old hands', rare and valued legacies from pre-war times, 'whom I have to stop working', and the personnel acquired during the war. This distinction was, he believed, recognized by many firms in his part of the country. Not one of the medical officers of firms which had expanded to meet the needs of war work failed to mention the increase of female labour or to complain of deterioration in the quality of personnel. Both of these factors were believed to affect rates of sickness and absenteeism. Comparisons with pre-war rates of firms which kept sickness figures were seriously invalidated by these factors.

There is another circumstance which may have a bearing. At the beginning of the war (1940) there were over a million registered unemployed in Great Britain. Among the chronic 'out-of-works' there may well have been a higher proportion of persons suffering from psychopathies than among those at work. Many of the former have now been absorbed into industry and may have added to the number of those who reacted unfavourably to current stresses.

4. Sickness rates and classification of the different forms of sickness were necessarily affected by the certificates received from panel practitioners. I.M.O.s were unanimous in praise of the work done by these under conditions of abnormal pressure and difficulty. Nevertheless, there were complaints of what was called 'loose certification'. The large sums of money earned by certain families with many members concerned in industry was held responsible for a relaxation of economic incentives. Pre-war anxieties as to loss of job were now very rarely felt. Many could afford to take days off when they felt like it or when it suited them. Panel practitioners found it difficult to resist the pressure for certificates. One I.M.O. remarked: 'Everyone wants a clean, light, quiet, well-paid job as near home as possible. My firm has few of these to dispose, being concerned with heavy industry. Yet I get frequent recommendations from panel practitioners that people be fitted into such jobs.' Another I.M.O. had noticed that a few of his young female workers brought him, in regular alternation, certificates from two doctors for different complaints. (These two doctors were quite

unaware of how they were being played off against one another.) 'Some panel doctors', remarked this I.M.O., 'are turned into rubber stamps. I don't blame them; I blame the system.' Another advocated a division of duties, one doctor being responsible for treatment and another, who risked no financial loss, for certification. Another informed me that he had had certificates for 'gastric stomach'. Another that the local branch of the B.M.A. had recommended that entries as to diagnosis on sickness certificates should be limited to the words 'sickness' or 'accident.'

The value of sickness records and statistics is obviously impaired by what has been called 'loose certification'.

5. Inquiries were made of every I.M.O. interviewed as to local facilities for obtaining psychiatric opinions or treatment. There was a consensus of opinion, with a few emphatic exceptions, that these facilities could be improved. But the relations between the I.M.O. and the psychiatrist were often indirect. The position is affected by the statement of *Duties of and Ethical Rules for Industrial Medical Officers*, drawn up by the British Medical Association. The statement of these rules, as approved by the Association's Representative Body in 1937, contains the following passages:

'The Industrial Medical Officer shall render such emergency or first-aid treatment as is required at the place of employment, and shall inform the worker's own doctor of any treatment given. Where further treatment is deemed necessary, the worker shall be instructed to consult his own practitioner.'

'The Industrial Medical Officer shall not provide treatment in cases of disability, save in such instances as may be covered by an understanding with a committee representative of the local medical profession, or where there is an *ad hoc* agreement with the worker's own practitioner.'

'The Industrial Medical Officer shall not, except in an emergency or where a prior understanding with the local practitioner is in operation, send any employee to hospital.'

An experienced I.M.O., who knows well the medical resources of his area and who is on friendly personal terms with the neighbouring general practitioners, works out harmonious working arrangements with them. Many of the latter are so busy that they are glad of any help. In such circumstances the I.M.O. feels himself at liberty to refer a patient for whom he desires a psychiatric opinion or treatment to the nearest psychiatric clinic. The clinic's staff may be personal friends and he knows what services they can give. But if the I.M.O. is a comparative newcomer, he may take some time to feel his way. He may consider that it is not his business to arrange for second opinions or treatment. This he leaves to the worker's own doctor, to whom he may send, at most, a recommendation that a psychiatric opinion or treatment be obtained.

Several of the I.M.O.s interviewed were ignorant of the psychiatric services of the area. They felt that they were precluded from entering into direct relations with psychiatric clinics by restrictive ethical rules.

6. All the I.M.O.s were asked whether an increase in neurosis

had been observed. A frequent and characteristic answer was: 'It depends on where you draw the line.' This is a very proper answer, and it goes to the heart of the problem which confronts every investigator of neurosis. It depends where you draw the line. The line is very difficult to draw with certainty, or with the assurance that it will be similarly drawn by other investigators now or in the future.

This difficulty—about the proper demarcation of neurotic illness—was felt by all the experienced I.M.O.s with whom the matter was discussed. It was expressed in a variety of terms. Here is an epitome of representative opinions, spoken by an imaginary I.M.O.:

'There is a core of genuine organic sickness or disability. One would include here the effects of accidents, of industrial diseases and also definite illnesses such as influenzas, sore throats, respiratory and catarrhal diseases (often epidemic), etc. I call these "tangible" diseases. They might comprise a few cases of "text-book" neuroses—anxiety states with tremor and sweating, definitely hysterical or obsessional conditions, etc. These cast clear and well-defined shadows outside which, like a penumbra fluctuating in range and scope, extends a variety of "intangible" illnesses in which psychological factors play a large and variable part. These "borderline" conditions are the product of two independent factors—the aggravation of current stresses for a deteriorated personnel and the loss of incentives which operate in normal times. Among aggravated current stresses caused by the war, long hours take first place; travelling difficulties and transport problems to and from work take it out of people: so does the blackout; many recently established factories had teething troubles and, in their early stages, ventilation, sanitary arrangements, canteens, etc., were necessarily imperfect. There were difficulties about allocation of responsibilities; labour managers, foremen, charge hands were often appointed with insufficient training. Personal problems were not always handled understandingly or tactfully. There are fewer good men to pick from; the able-bodied have been drafted into the Services and the quality of our labour is not what it was. There is a big dilution by female workers.

'But there is another side to the account. There are no anxieties as to tenure and security of job. Indeed, the difficulty is not so much to find work as to change it if you feel it to be uncongenial, owing to the operation of the Essential Work Orders. And high wages are being earned. The economic incentive to hold on to your job does not operate as it did. As much as £20 a week are coming in to some families in this area. People can afford to take a week or so off when they feel like it. Then there is the factor of boredom. One day is just like another, and with the long hours the strain begins to tell. The worker has lost much of his ordinary annual holiday, a deprivation which is particularly felt by key men and women. Many people are holding down two jobs: men are working at the factory and also fire-watching; or doing Home Guard duties. Women have homes to look after: their children get ill: they have

to do their shopping at inconvenient hours, often late in the evenings when the shops are sold out; they have to wait in queues; they may have meals to prepare and the washing to do. Many people are anxious about near relatives overseas, or in the Navy or the R.A.F. Much of the transferred labour is unaccustomed to factory work; some of the girls have never been away from home; some can't stand the noise; some develop phobias of machinery; many are lonely and unhappy in their billets.

'All such factors have psychological effects and produce what I call "intangible" illnesses equivalent to a lack of well-being. They are not neuroses according to the text-books; they might rather be described as "nervous illnesses" in a wide and general sense. Not all of these, in my opinion, call for the attentions of a psychiatrist. What is needed for most is a rest and a change. A fortnight at a Rest-Break Centre by the sea, with a change of food and air, complete relaxation, no duties or responsibilities and plenty of sleep, will in many cases, do all that is necessary.'

The above statement is more complete than any received from a single I.M.O. Yet it embodies, in part or in whole, views expressed by them all. It represents approximately their collective view. There follow the opinions and experiences of certain individual men.

The Post Office is numerically the largest employer of industry in the country. For many years past it has kept accurate sickness records of all its established staff from the ages of, roughly, fourteen to sixty.

There is evidence of the effects of the stresses of war and of air raids in: (1) an increase in the year 1941 of the number of retirements due to ill-health throughout the whole established staff (approximately 185,000): (2) an increase in the same year, and within the same group, of retirements due to nervous disorders; (3) an increase of sickness absenteeism in 1940 and 1941 in London and other large cities which were targets for air attack. Here are the figures for which thanks are due to Sir Henry Bashford, late Chief Medical Officer to the Post Office:

(1) *Retirements from Post Office due to Ill-Health* (*Whole Established Staff: Average Nos.—Males*, 140,224; *Females*, 42,903)

	1938.	1939.	1940.	1941.	1942.
Males . .	1002	907	869	1203	883
Females . .	241	274	298	414	272

The increases in 1941 are marked, and largely occurred in the London area; they were almost certainly attributable to the intensive enemy action between September 1940 and May 1941.

(2) *Retirements from Post Office due to Nervous Disorders: Rate per Thousand of Whole Established Staff: Average Nos.—Males*, 140,224; *Females*, 42,903

	1938.	1939.	1940.	1941.	1942.
Males . .	1·2	1·1	1·1	1·9	1·0
Females . .	2·0	2·5	2·4	3·8	2·1

Again a rise in 1941 is conspicuous, and was almost certainly to a considerable extent due to intensive enemy action between September 1940 and May 1941. (These ratios include organic nervous disorders, so that the retirement rate for neuroses would be somewhat less.)

(3) *Post Office : Sickness Absence in London in Average Days per Head of Staff—*

	1936–38.	1940.	1941.	1942.
Headquarters : Male Sorters .	7·3	9·2	9·1	9·4
Headquarters : Postmen .	8·2	10·3	9·1	10·5
Telephonists (Female) in Inner London Area . .	10·9	17·9	15·9	14·5

Rises after 1938 are noticeable.

(In assessing these figures, it must be remembered that, owing to the demands of the Fighting Services, they apply, on the men's side, in the war years, to a considerably older staff.)

Post Office : Total Female Staff : Sick Absence in Three Large Towns subjected to Air Attack in 1940 *and* 1941, *Average Days per Head of Staff—*

	1936–38.	1940.	1941.	1942.
1.	9·6	10·8	15·7	14·7
2.	11·8	16·7	18·3	15·4
3.	8·5	10·6	13·5	10·0

Rises in 1940 and 1941 are again noticeable.

There is evidence also of an increase in minor nervous disorders from the *Central Bureau for Insurance Nursing*, which operates a scheme of Home Nursing on behalf of certain Insurance Companies. The services of District Nurses are included in the scheme. The Central Bureau has kindly analysed the diagnoses suggestive of neurosis, made before and during the war. The following is a list of such diagnoses : Debility, Nervous Debility, Neurasthenia, Industrial Fatigue, Exhaustion, Nervousness, Nervous Trouble, Nervous Strain, Nervous Exhaustion, Cardiac Debility, Anxiety Neurosis, Nervous Breakdown, Air-raid Shock. The following table shows the numbers and percentages of the above diagnoses, between the years 1938 and 1942, among cases who were 'acceptable for nursing care' :

Central Bureau for Insurance Nursing: Numbers and Percentages of Diagnoses suggestive of Neurosis among Cases acceptable for Nursing Care—

	1938 (Oct.–Nov. only).	1939.	1940.	1941.	1942.	1943.
Cases acceptable for Nursing Care: Totals.	617	2742	2976	2341	2796	3868
Diagnoses suggestive of Neurosis:—						
Numbers . .	17	65	38	110	189	198
Percentage of Cases acceptable for Nursing Care . .	2·8	2·4	1·3	4·7	6·8	5·1

There is an obvious increase of numbers and a rise in percentages, in 1941, 1942 and 1943, of diagnoses suggestive of neurosis.

How many of these cases are to be counted as definite neuroses and how many as 'intangible illnesses' or 'minor maladies'—*i.e.* as reactions to aggravated current stresses in the sense in which these terms were used in a preceding paragraph? It is difficult to answer this question with accuracy, but the procedure of the Central Bureau for Insurance Nursing throws some light. The appropriate District Nursing Associations were informed by a process of 'automatic notification' of the absence from the factories, etc., on account of illness or accident, of workers included in the scheme. Less than half (41·4 per cent) of workers so 'automatically notified', were deemed 'acceptable for nursing care'. Indeed, the phrase was used to denote a case where (*a*) a doctor was in attendance, and (*b*) there was some definite nursing to be done (though 'nursing' was interpreted in its widest sense, and did not necessarily imply 'bedside care'). The cases 'acceptable for nursing care' thus included all 'notified cases' who were definitely ill, and excluded the medical or surgical trivialities. The table shows an increase in the incidence of diagnoses suggestive of neurosis in 1941 and 1942; and the cases in question were sufficiently ill to call for medical attendance and nursing.

There was general approval among I.M.O.s of the principle of vocational selection as a guide to placement in industry; but the question was answered in the light not so much of peace-time problems as of those presented by directed and transferred labour. Many transferred women workers were inexperienced in industry and unfit for employment in the industries to which they were sent. Misfits were frequent. Physical examinations and vocational tests carried out before leaving the home district would, it was felt, save expense to the State, inconvenience to the employer and mental stress to the worker. Few I.M.O.s had had first-hand experience of occupational selection. Those who had, praised the results; those who had not, were disposed to think well of it.

With a fair unanimity, the I.O.M.s interviewed did not think that the air raids had played an important part in the increase of nervous ailments. In one area which had been little affected by raids, an I.M.O. said that in his opinion a few air raids would do good. 'People here,' he said, 'seem to regard the war as won (March 1943). An air raid or two would provide a stimulus and bring home to people that there was still a war on.' And they would relieve boredom. The factor of boredom with a life with nothing to look forward to was stressed by several I.M.O.s, three of whom said that the air raids had stimulated rather than hindered production. Sir Henry Bashford, however, was satisfied, as regards the Post Office, that the intensive bombing of London and certain other large provincial towns was responsible for an increase in retirements. These were mainly confined to older people and to a certain number of young people who definitely broke down under the strain. But a careful investigation of a group of these showed that, in each case, there was a history of previous maladjustment.

Several I.M.O.s stressed the fact that neurotic conditions were more prevalent among the responsible and semi-responsible than among the rank and file of workers—especially such psychosomatic disturbances as nervous dyspepsia, fibrillation and cardiac arhythmias. Another added gastric ulcer and coronary thrombosis. Those I.M.O.s who were most conscious of the relation above mentioned between the incidence of nervous illness and the stresses of responsibility were keenest to have available good facilities for psychiatric diagnosis and treatment. 'The majority of these cases', one said, 'are worn out by the long hours and the added strain of responsibility; all they need is a rest and a change. But a minority require something more—they need special treatment. There may be something wrong in their home lives. Or they may be unduly ambitious or jealous, in which cases they may be contending against a sense of frustration. Or they may have twists or defects of character. Such types need some sort of treatment, probably psychotherapy.'

Several I.M.O.s stressed the obverse side of this problem—the effect upon the rank and file of workers of being under the authority of wrongly chosen people. There was much support for the thesis which has been well put by Sir Henry Bashford,[1] late C.M.O. to the Post Office:

> 'In the exercise of medical supervision of sick absence, the industrial doctor will soon come to appreciate the importance of lay supervision by foremen, forewomen, heads of offices or departments or works managers. It would probably be unwise that he should have any direct voice in their selection, and thus come to be regarded by the staff as an agent of promotion; but he should certainly be given the opportunity of putting certain aspects of lay supervision to would-be candidates for the work, since it is on the qualities of a lay supervisor—his or her own health, self-control, sympathy and tact—that sick rates will largely depend. An instance of how profoundly a change of lay supervision may work is shown

[1] *Lancet*, 5th Sept. 1942: 'Supervision of sick absence in Industry.'

by the average annual sick absence, in days per head, of the following five groups of workers all in one office :

	Men.			Women.	
1st year . .	15·0	15·4	14·7	24·5	25·8
2nd year . .	16·7	14·1	23·5	35·1	39·8
Change of Lay Supervision					
3rd year . .	8·0	6·9	13·2	22·1	12·9
4th year . .	7·0	7·3	10·3	14·3	10·7

' The change of lay supervision was not the only factor in this immediate reduction, but it was undoubtedly the principal one—the conversion of the office concerned into what the sailors call a happy ship.'

This thesis—the bearing on sickness rates of the quality of lay supervision—was supported by the experience of many I.M.O.s ; especially of those in the big ' mushroom factories ' which, under the Ministry of Supply, had grown up in a few months to meet the special needs of war. In such hastily assembled concerns there was no nucleus of tried and trusted workers to form the skeleton round which the rest could grow. The best had to be made of such human material as was directed, and this sometimes left much to be desired.

Such considerations bring clearly to light the difficulty, in assessing the volume of neurosis in a given place and at a given time, of *where to draw the line.* Among women workers in a single office, sickness rates are more than halved by a change for the better in lay supervision. Sickness of this character is rightly described as ' intangible '.

One I.M.O. remarked of conditions prevailing in war-time : ' The factor of fatigue influences all the sickness figures.' Another divided the causes of absenteeism under three headings : Sickness, domestic and personal reasons. In the first category of sickness he distinguished between major and minor illness, the latter often little more than a general tiredness which might be called unwellness. Domestic reasons were classified under six headings : care of children ; care of other dependants ; sickness in the family ; shopping duties ; husband, etc., on leave ; domestic duties, including washing. Personal reasons were, as is to be expected, heterogeneous and variable. Behind most of them is the lack of incentives. Large family earnings, the effects of income tax and of unrestricted spending powers, the worker's failure to fit himself into the picture of what the factory is doing in the war effort, combine to reduce incentives. ' The feeling of being a part of the war effort should provide the strongest incentive in war-time.' Too often this feeling is weak or absent.

These three causes of absenteeism enter into kaleidoscopic relations with each other. The domestic and the ' personal ' causes can masquerade as illness or, under conditions of great stress, can genuinely take illness's form.

I.M.O.s were asked what part nervous illness played in their sickness figures. What was the percentage? The answers varied between 2 and 75 per cent. It depends on where you draw the line.

CONCLUSIONS.

The first of the two objects of this part of the survey was to find out if there had been an increase of neurosis in industry since the war began. It will be seen from what precedes that it is not easy to give a straight answer to this question. Here are the main conclusions:

1. The causes of neurosis are closely linked with those of absenteeism, which presents a bigger problem in industry to-day than before the war.

2. Neuroses in the strict text-book sense are difficult to separate from the 'reactive debilities' produced by aggravated current stresses in a working population much diluted with female labour of inferior quality judged by pre-war standards, and lacking in the erstwhile economic incentives.

3. These 'reactive debilities' are given various diagnoses by panel practitioners; they appear to the I.M.O. as minor maladies or intangible illnesses wherein the factor of genuine disability combines with elusive domestic and personal causes of absenteeism and with the prevalent industrial fatigue to produce a general state of 'unwellness'.

4. There is some evidence of an increase of disability due to neurosis from the records of the Post Office and of the Central Bureau of Industrial Nursing.

5. Among 'current stresses', long hours take first place for key persons; the following also play a part: transport problems, the blackout, duplication of factory work with home duties (such as fire-watching and Home Guard), shopping difficulties, industrial misfits (especially among transferred workers), anxieties about relatives in the Forces, trouble resulting from the promotion to positions of responsibility of ill-chosen or imperfectly trained people and boredom.

6. There is a general agreement, though there are a few emphatic exceptions, that the air attacks on this country have produced little in the way of overt neurosis and have directly contributed little to the current stresses which have affected industry.

7. The difficulties brought up in this survey, of assessing the disablement caused by neurosis, are powerful arguments in favour of intensive and carefully planned investigations, such as those now being carried out by Dr. Russel Fraser under the Medical Research Council.

REMEDIES.

The second of the two objects of this part of the survey was to find out if the psychiatric services at the disposal of industry were adequate and sufficient. Here again is a somewhat complex problem.

The central question is this: How much of the minor maladies

and 'intangible' illness which are a reaction to fatigue and to aggravated current stresses call for the attentions of a psychiatrist? It is important that the matter be kept in its proper perspective and that exaggerations be avoided.

There can be no doubt that much of this 'reactive debility' will cease when current stresses are reduced by the ending of the war; likewise that much of it will persist as long as these stresses remain what they are. This fact was generally recognized by I.M.O.s, whose point of view is probably reflected in a memorandum which the I.M.O. of a big manufacturing firm in the Midlands submitted to his management. This is what he wrote:

'The cure, in my opinion, of increased absenteeism (largely of the nervous type), cannot really be found or even discussed by a worried management until that management can answer in the affirmative the following questions:

Are the hours reasonable and compatible with good health?
Are wages reasonable and uniformly satisfactory throughout the works?
Is welfare, male and female, all that it should be?
Do the transferred workers get the special care, thought and attention given to them that they truly need?
Are the shops ideal or as nearly ideal as possible in these days, as regards ventilation, lighting and general cheeriness?
Are all the foremen selected as much for their ability to handle the human machine as well as the production machine?
Is everything done to relieve boredom? What about music?
In short, is work in the factory made as pleasant, attractive and congenial as possible?

'I suggest that no management can have a justifiable grouse about increased absenteeism, sick or otherwise, and increased turnover, until they can answer each and all of these questions—Yes—100 per cent.'

The reduction of current stresses while the war lasts is one of the main problems confronting the Ministry of Labour and National Service. Some stresses, doubtless, will be mitigated, particularly after the war in Europe comes to an end, such as air raids, the black-out and the duplication of work in the factory with fire-watching and Home Guard duties. Others, however, may persist till the war ends. And new problems will then arise. Among these will be the reinstatement in industry of men demobilized from the Forces and of repatriated prisoners of war. Both these groups, especially the last, will have psychological difficulties to surmount, and will need careful handling. This matter is further discussed in Part II of this report.

To meet the special needs of the war, an experiment has been started which has amply justified itself—the War-time Rest-Break Scheme. A rest-break house is a place where industrial workers suffering from the effects of accumulated fatigue can recuperate in an atmosphere free from rules, regulations and regimentation. No medical treatment is provided and there are no attempts at rehabilitation. The patient is in no way 'investigated'. Sick and overtly neurotic people are not received, and the promoters of the scheme think that its purpose would be defeated if the guests came to feel

that they were being hospitalized or regarded as patients. In the view of the Advisory Committee concerned with the promotion of these places, their rôle is prophylactic, not therapeutic. 'The object is to reach the flagging worker *at her work*. Great care is taken not to confuse rest-breaks, which are purely preventive, with ordinary holiday bookings on the one hand and with post-illness convalescence on the other. . . . Two weeks' rest may save six weeks' loss of production through illness. A tired or flagging worker impedes production, increases the danger of accidents and adds further burdens to the health service.' Each rest-break house is in the charge of a warden : it accommodates from forty to fifty inmates, who sleep in rooms holding two to five people, though a few single rooms can be had if desired. A restful holiday atmosphere is maintained and there are few rules. The best food (four meals a day) is provided, with special diets if necessary. There are no organized activities, for what the workers most want is a change from regimentation at their work and also, sometimes, in their homes.

The scheme had its origin on the Merseyside in the year 1940, and has since received encouragement as well as financial support from the Ministry of Labour. Through the oldest established rest-break house (that at Abergele in North Wales) there had passed, by March 1944, 2500 women and girls from over 400 factories in the north-west of England, who made an average stay of a fortnight. With the help of generous grants from the U.S.A., ten rest-break houses have now been founded in different parts of the country, including Scotland. One of these houses is for men.

The assumption made by the rest-break movement is that the flagging worker, suffering from 'accumulated fatigue', wants not medical or psychiatric treatment but a rest. What started as a local experiment sponsored by a voluntary organization has flourished and expanded. The movement now has official support and is being organized on a national scale. Valuable results are easily obtained at a small cost, and give much satisfaction to all concerned. The participation of the country's psychiatric services is unnecessary, and might do more harm than good. It is to be hoped that the rest-break houses will survive the war and become a permanent feature of the nation's industrial services.

In a minority of cases, however, the appearances of accumulated industrial fatigue may be presented by people who are in fact the victims of a more serious maladjustment or of a latent neurosis. Such persons will improve temporarily in response to a fortnight's rest-break, but will quickly relapse. They will come to be recognized by the I.M.O. as difficult or awkward cases, who are in need of further investigation or treatment. To meet the needs of such cases, Dr. T. M. Ling has initiated experimentally a special rehabilitation centre at Roffey Park in Sussex, the establishment of which was originally welcomed by the Ministry of Labour and National Service. This and similar centres may well prove useful for men demobilized from the Forces and repatriated from prison camps who have serious

difficulties in adjusting themselves to jobs in civilian life. These groups are not unlikely to present a grave and urgent problem ; and appropriate means of therapeutic disposal should be prepared for them beforehand.

The Rest-Break House is designed as a preventive measure : the Industrial Rehabilitation Centre has a similar object, though it is further equipped to investigate, treat and recommend on cases of misfit or neurosis. Another important agent in the prevention of industrial illness, especially its minor forms, is the I.M.O. himself. The number of these has increased since the beginning of the war. In April 1944 there were employed in industry 164 full-time and 673 part-time I.M.O.s. But the small factories are still uncovered by this service which is likely to expand ; and there are as yet few medical services for other types of industry.

The I.M.O.'s rôle is as much prophylactic as therapeutic. In this connection a further extract may be quoted from the article already referred to (p. 30) by Sir Henry Bashford :

' It is perhaps in the great field of minor maladies—in which temperament, anxiety, lack of a sense of responsibility, maladjustment and physical ill-health meet and mingle and influence each other most—that the supervision of sick absences in industry can play its most valuable part and give an opportunity for preventive medicine. The sick absences of two or three days, or less than a week, are probably about four times as frequent as those of a week or more, although this may not—perhaps owing partly to the present form of panel certification—be reflected in the statistics of sick absence under the National Health Insurance scheme. Many of these short sick absences may be due to organic causes, such as decayed teeth or septic tonsils, a lack of resistance to some particular common pathogenic organism, or some form of minor chemical allergy ; and the proper routine supervision of sick absence should give the industrial doctor the opportunity of suggesting an appropriate remedy. But there will remain a considerable number (though a minority) in any large staff of employees with an abnormal yearly record of minor sick absences, for which no obvious organic basis can be found. And it is among these that the industrial doctor—provided he has sympathy and common sense and the insight that grows with experience—can be most valuable, especially to the young.

' Over and over again he will find some such factor as groundless anxiety, thwarted or seemingly thwarted ambition, some personal antagonism, real or fancied, to a particular job or fellow-worker or foreman or office superior ; and he will be able to make an adjustment which results in an immediate and permanent alteration in the sick record. Or he may find some factor of irresponsibility, not of malingering in any serious sense, but of a too light-hearted taking of a day or two off for medical or semi-medical reasons. Few people, and especially young people, memorize their own sick records ; and many when confronted with them in black and white are genuinely surprised by their extent ; often a complete alteration is the result. If there is no change and no definite physical or psychological cause is discovered for repeated minor sick absences, a kindly intimation that if the record continues as in the past the question of retirement or discharge on medical grounds will arise may have a considerable effect. This was illustrated in a group of workers on whom I have previously reported. Over about 4 years this group of 40 people, mostly young, had incurred between them 736 separate sick absences,

totalling 6194 days; after receiving the intimation described, these 40 people during the next 6 months only incurred 54 days' sick absence, their 6-monthly average of illness dropping from 19 days a head to 1·3. It would be unfair to describe supervision of this sort as medical police-work in any vindictive sense, since it was clearly of benefit not only to the departments but to the workers concerned; and it may be that such supervision may prevent the development in later years of a valetudinarian outlook on life much harder to combat. In any large staff there will also probably be cases in which the real reason for continued minor illnesses is a fundamental dislike to the particular occupation. In such cases, medical advice to seek some other mode of life is probably in the truest interest of the employee.'

The writer, who emphasizes that in his experience true malingering is very rare, recommends that the I.M.O. should keep a friendly eye on the workers under his charge in order to study, and if possible, to suggest measures to reduce, these multiple sick absences. Sick records of this complexion are found in a minority only of employees: these may sometimes be harshly, perhaps wrongly, criticized by their fellows, who may incur from them added burdens. It would be a mistake to regard the course above advocated as a bureaucratic regimentation of the worker. The truth is quite the contrary. It is to be regarded, not only as a means of protecting the normal, dependable and trustworthy majority from real or apparent exploitation by such a minority, but also as an endeavour to understand and help to solve the problems, physical and psychological, of this minority.

Rest-break houses have been established to forestall the effects of accumulated fatigue among women workers in war-time. The 'preventive' activities of the I.M.O. described in the above quotation are also called for in times of industrial stress like the present, when the field of minor maladies is large and when economic incentives are reduced. How far will they be needed when the conditions of peace are restored? The question is difficult to answer with finality because we are ignorant of how long it will take for industry to return to its normal peace-time basis, and uncertain about the new conditions which will then prevail. After hostilities in Europe come to an end, the war will be continued in the Far East. And when the final goal is achieved, there will remain much to be done. Frictions and stresses may accompany the translation from a war to a peace footing of industry and the absorption of several million demobilized and repatriated men. A vast rebuilding programme is contemplated, to which many war industries will be adapted. The country will doubtless try to regain the economic position in the world which it held in the past. This goal can only be reached by hard work. The programme of social security which has been promised can be realized —and paid for—only if industry is active and unemployment restricted within prescribed limits. The employment of women is likely to continue for some time to come.

What will be the effects of 'social security' upon economic incentives? The worker will enjoy the benefits of insurance against unemployment. The fear of losing his job—a fertile source of anxiety

and mental stress before the war—will be lifted from his shoulders. It is possible that the weakening of economic incentives produced by the large earnings of war-time may reappear under a new guise when the loss of one's job is no longer feared. The interests of the trustworthy and conscientious majority of workers, as well as the interests of the community as a whole which has to foot the bill, may need to be protected from abuses of social security by a less staunch and dependable minority. Industry will continue to make exacting demands. 'There is no universal standard for assessing fatigue,' it has been said, 'because individual factors have to be taken into consideration. Certain general rules can be laid down, but individual reactions cannot be predicted: hence it is important to watch the health of the employees new to a job.' 'Accumulated fatigue' may be experienced by newcomers to industry, working side by side with men whom experience has made immune. The preventive benefits of the rest-break services will continue to be needed; they might even be extended to the housewife exhausted by domestic duties and, on a larger scale than heretofore, to male workers of all ages and occupations. These services should be encouraged to continue at least for a period; they may be found to have a definite place in the country's mental health services. The supervisory and preventive duties of an industrial medical service, extended to embrace the whole industrial population, will still be in demand. For the minority who need psychological investigation and treatment, amplified psychiatric services and an appropriately framed rehabilitation service should be available.

CONCLUSIONS.

1. Not all the minor mental maladies and reactive stresses which are a feature of industry in war-time need the attentions of a consultant psychiatrist.

2. Many cases respond to a fortnight's rest-break. The Rest-Break Service, started as an emergency measure during war-time, should be continued at least for a period after the war.

3. A careful selection of foremen, forewomen, heads of offices and departments, works managers and welfare officers would lessen avoidable stresses and reduce the tasks of the Mental Health Service.

4. The I.M.O., by appropriate supervision and guidance, can check minor absenteeism as well as detect cases needing a rest or special treatment. The Industrial Medical Service coupled with welfare services should be extended so as to embrace the whole industrial population.

5. A minority of cases for whom an opportunity for rest and recuperation is not enough will need the attentions of a consultant psychiatrist. These could be provided both through an appropriately constituted rehabilitation service and through the general psychiatric services of the country. The latter should be better equipped to deal with problems of industrial psychiatry. Suggestions as to how this might be done are put forward in Part II.

PART TWO

POST-WAR PSYCHIATRIC SERVICES: LONG-TERM CONSIDERATIONS

In Part I of this report the main findings of the neurosis survey were summarized and certain questions arising from it reviewed. The results and conclusions form a basis on which the future organization of the psychiatric services can be discussed.

But there are certain preliminary considerations which call for notice. These—the sociological context of preventive psychiatry, the rifts and divisions of the subject and the priorities which confront the builders of a psychiatric service—will be briefly reviewed.

CHAPTER VI

INTRODUCTION

1. Preventive Psychiatry a Mainly Sociological Question.

The first aim of a comprehensive and free medical service should be to prevent disease. Disease is caused by the interaction of factors inside and outside the individual, by the interplay of genetic predispositions with influences exerted by the environment. It is the joint product of nature and nurture. Genetic factors play a more obvious part in psychiatry than in most other fields of medicine. They contribute much to mental deficiency, especially the higher grades, and to mental subnormality; to many forms of psychosis; and together with adverse influences beginning in infancy, to various manifestations of neurosis. But these genetic factors are complex and difficult to assess. Compared with them, causes arising in the patient's environment are easy both to recognize and to control. It is easier to improve the conditions in which a people live than to change that people's inborn qualities; yet both are tasks for the sociologist.

From a recognition of the influence upon health of how people are reared, work, behave and live in their homes, has developed what is now called social medicine, which is an aspect—the medical aspect—of sociology. Preventive psychiatry together with preventive medicine as a whole has its roots in sociology.

The following are among the sociological changes which have a bearing upon preventive psychiatry:

Better education of adults in the sensible handling of children—in what habits of mind to instil and what emotional situations to avoid. There is a psychological as well as a physical aspect of infant and child welfare. Useful work has been done by

voluntary societies in preaching and teaching what is called mental hygiene or mental health.

Better educational services, with facilities for the early detection of mental defects or disorders; the provision of appropriate training from the earliest age for handicapped children. Early recognition of, and provision for, children with abilities above average. Innovations valuable from the psychiatric standpoint are embodied in the Education Act.

Better social standards of nutrition, housing and town-planning, such as will promote fullest *physical* development and health at all ages. Corresponding *psychological* benefits would follow from improved social services designed to encourage family life and minimize the fears and consequences of illness, unemployment and destitution.

Improved working conditions and leisure facilities.

Better industrial, occupational and social psychiatry, including vocational guidance, all designed to secure good occupational adjustment.

Limitation of fertility of prolific and at the same time constitutionally inferior types. Arising from an inquiry into the causes of mental deficiency, the Wood Committee (1929) drew attention to the existence of a 'Social Problem Group' consisting of persons who exhibited multiple social problems. Among the persons in the group, a high fertility—the product mostly of unwanted and haphazard pregnancies—is associated with a high incidence of mentally defective (mostly high-grade) and mentally subnormal persons, insane persons, epileptics, psychopaths, paupers, criminals (especially recidivists), unemployables, habitual slum-dwellers, prostitutes, inebriates and other social inefficients. Social and genetic factors contribute jointly to this picture; but in the measure that the former are improved, the latter will be brought into prominence.

These reforms would do much to prevent psychiatric illnesses. Though all belong to the province of sociology rather than of medicine, the voice of the doctor—and especially that of the psychiatrist—should be heard with the voices of other advocates of social reform.

2. Rifts in Psychiatry : its Partial Insulation from General Medicine.

Services for the accommodation and treatment of psychotics and mental defectives have developed as a segregated specialty (institutional psychiatry) somewhat cut off from general medicine. Separate buildings are used, a full-time salaried medical staff is employed and different examinational standards for nurses largely prevail. By contrast, services for the diagnosis and treatment of neurosis have developed as a recent movement in general medicine, for the most part in Voluntary Hospitals and mainly limited to out-patient work. But as a result of developments of the Mental Treatment Act (1930), psychiatrists based on Mental Hospitals now take an important and

increasing part in out-patient work, and the majority of psychiatric clinics in England and Wales are now staffed by them. The neurosis survey, however, has shown that there still remain certain broad differences between psychiatric clinics staffed by psychiatrists based on Mental Hospitals and those otherwise staffed (see Part IV (19), p. 183).

Child guidance—an important development of modern psychiatry—has evolved as an independent movement, insufficiently linked with general medicine (paediatrics) and little related to institutional psychiatry. At the beginning of 1944, of 95 child guidance clinics, 22 were served by psychiatrists who belonged to the staffs of Mental Hospitals. Doctors working in colonies and institutions for mental defectives should take a more active part in the child guidance services.

Intelligence and other mental tests, vocational guidance and much industrial psychiatry are a development of non-medical psychology as well as of psychiatry. Mental and other tests have been used with much success in the Fighting Services as part of a general assessment of personality whereby placement is determined. It is now clear that testing procedures have a future both in the educational services and in vocational guidance. They should form part of a system of preventive psychiatry.

Thus, in the last twenty years, psychiatry had developed new growing points in what, for the institutional psychiatrist, is the outside world. There is to-day a need for an integration of the subject, comprising these new developments. It would be regrettable if a schism occurred between a restricted and 'closed' psychiatry, limited to psychoses and mental defect, and an extra-mural psychiatry (perhaps called 'medical psychology') concerned with neuroses, child guidance, industrial psychiatry and prevention. That these two provinces should be integrated rather than further separated is the main argument of the recommendations which follow.

3. Priorities.

Better psychiatric services need, in the following order of priority, four things:

Good psychiatrists in sufficient numbers. The specialty should attract able men with an interest in and aptitude for the work; teachers of psychiatry should be on the look-out for these. Similar remarks apply to nurses.

Good all-round training for psychiatrists and for psychiatric nurses in sufficient numbers.

Good accessory services in sufficient numbers.

Good buildings and material facilities.

It would be a grave mistake to embark on big schemes involving extensive new buildings and new organization if adequate personnel were not available. Good men and women count for more than modern buildings and expensive equipment. A good psychiatrist produces good results wherever he does his professional work. An indifferent

psychiatrist will produce indifferent results however luxurious and well appointed his material surroundings.

Good all-round psychiatrists cannot be produced at a moment's notice. Men and women who have benefited from the revised psychiatric curriculum which is now under discussion will not be graduating for another five years. Interim arrangements, especially affecting post-graduate training, will have to cover the difficult 'transitional' period which will follow the beginnings of peace and of demobilization.

Not only must the psychiatric services of the future provide good guidance, diagnosis and treatment for those who need these things; it must also afford good teaching and training facilities for doctors, nurses and accessory services. The needs of the patient must be harmonized with the needs of the student to the advantage of both.

There is another priority which must figure prominently in any preventive service—the needs of children. I do not primarily refer here to the provision of psychiatric treatment for children showing disorders of behaviour, important though it is that these children and their parents should receive attention. I have in mind, rather, the need for detecting, at the earliest possible age, sub- or abnormalities which need to be taken into account in the educational curriculum or in the child's home life. Many studies have been made during the war of juvenile delinquency. One outstanding conclusion has emerged —the frequency with which delinquency is associated either with mental subnormality or with an unsatisfactory home background or with both. If every child were educated in accordance with his abilities and aptitudes—neither above nor below them, if every child were brought up in a happy and harmonious home, and if, on leaving school, every juvenile were fitted into the right job, much unhappiness, neurosis and delinquency would be prevented. A psychiatric service attuned to the needs of children should be able to detect these maladjustments at the earliest possible moment—before bad habits of mind become ingrained and bad patterns of conduct established. And there should be at hand means of disposing satisfactorily of such children. Educational facilities of a special kind should be available for them, and also adequate residential facilities whether in schools or with foster-parents. The needs of children will receive special prominence in the suggestions which follow.

CHAPTER VI

TRAINING OF PSYCHIATRISTS: THE TEACHING PSYCHIATRIC UNIT

THE psychiatrist's training can be considered from the standpoint of the curriculum and from that of the quality and range of the teaching. The curriculum could be approximately standardized for the country as a whole by some central authority; the quality and range of the teaching depend on less ponderable factors, such as the capacities of the teaching staff and the variety of clinical material within access of the teaching centre. These two aspects of the subject will be considered separately.

(*a*) *The Curriculum.* Three reports containing valuable recommendations have in recent months been produced by the Royal College of Physicians.[1] One deals with medical education as a whole and two with aspects of education in psychiatry. The important position of psychiatry in the future of medicine is here recognized by the number of hours in the student's training which the reports recommend should be devoted to psychology and psychiatry. Briefly, the College holds that, in the pre-clinical years, the student should attend a course consisting of from twelve to twenty lectures on *normal* psychology, to be divided between a psychologist and a psychiatrist; in this course, it is desirable that teachers of biology, genetics, social medicine and physiology should take part. During the clinical period, the College recommends that the student should attend a systematic course of lectures or demonstrations comprising all the important aspects of psychiatry. Over fifty sessions are included in this comprehensive schedule. It is further recommended that, during his last clinical year, the student should serve for a short period as a resident in a Mental Hospital or hold a clinical clerkship in an observation ward for two or three weeks.

For the Diploma in Psychological Medicine, a five years' training is deemed desirable; the candidate should be allowed to take the examination after three years. The report specifies how and where these five years should be spent.

(*b*) *Quality and Range of Teaching.* This subject has been fully dealt with by the Inter-Departmental Committee on Medical Schools (Goodenough Committee). Medical schools will be centred in the future as in the past upon universities. It should be possible for the mental health services of the future to be organized in loose affiliations or regional groupings round universities which will be concerned with various aspects of medical teaching and training.

The psychiatric department of every university medical school should be under the direction of a professor of psychiatry, who should

[1] Royal College of Physicians: (i) Planning Committee's Report on Medical Education, issued in April 1944; (ii) Committee on Psychological Medicine: Two Interim Reports on Undergraduate and Post-graduate Education in Psychiatry, October 1943 and October 1944.

have at his disposal, for teaching purposes, an adequate number of beds. A psychiatric department, consisting of an out-patient clinic, beds and accessory services (psychologist, psychiatric social worker, occupational therapists, etc.), is described in this report as a *Psychiatric Unit.*

A Psychiatric Unit, wherein undergraduate and perhaps post-graduate training is a recognized function, is here described as a *Teaching Psychiatric Unit.*

Psychiatry will, then, be taught in the Teaching Psychiatric Units which form an integral part of the teaching hospitals of London and provincial universities. Each teaching unit of a provincial university should be under the direction of a professor of psychiatry. Very much will depend on the personalities and abilities of these key men. Indeed, they will collectively exert a supremely potent and formative influence on the development of British psychiatry. The latter would benefit if these men came to be regarded not only as professors of schools of teaching, but as initiators and inspirers of schools of thought. Research is activated and energies stimulated by diversities of theory and varieties of practice, resulting from different affiliations and loyalties.

It will be convenient at this stage to consider the range of activities which might enter into the province of a teaching unit. This outline is not given in an attempt to lay down a programme of duties (which would need to be worked out by each unit for itself in relation to special conditions and needs), but rather to indicate generally the scope of activities which the Director of such a unit might legitimately cover if he so desired. These might be considered as follows :

(1) The unit would provide an all-round teaching of psychiatry in the out-patient departments and wards of their units. The latter would contain as wide a range of teaching materials as possible, including children if there were no psychiatric hostel for these near by.

(2) The unit would establish for teaching purposes close working liaison with such institutions and services outside their own teaching units as would provide supplementary instructions and teaching material. Among these outside organizations would be the following :

For In-Patient Work :

Mental Hospitals containing chronic psychotics and such acute cases as are not normally seen in the teaching psychiatric unit ;

Certified Institutions and Colonies for mental defectives ;

Epileptic Colonies and Homes for drug-addicts and inebriates.

For Out-Patient Work :

School medical and psychological services ; special schools.

Statutory Committees and Voluntary organizations dealing with the welfare of educable mental defectives and with the care

and after-care of the mentally unstable; hostels for various classes of abnormal or subnormal children.

Rehabilitation services, especially those dealing with neurotics.

Organizations connected with industrial medicine.

Prison medical services, remand centres, prison remand homes, Howard Houses and other institutions which may be established under the Criminal Justice Bill; Remand Schools.

Magistrates, especially those of Juvenile Courts.

The Teaching Psychiatric Unit should also have close links with other University departments dealing with Social Science and Psychology, where these exist.

(3) The unit would play a full part in any university scheme of post-graduate training for general practitioners and others; give special post-graduate facilities for intending specialists in psychiatry; provide refresher courses for psychiatrists in the Mental Hospital services of the area.

(4) The unit would contribute to the training of psychiatric social workers if a school for these were established in the university; the unit should also assist in the training of other accessory services—psychologists, occupational therapists and perhaps speech therapists—in so far as this may be called for by future developments.

(5) The unit would provide, if appropriate to the area's psychiatric organization, a Central Pathological Laboratory and Service.

(6) The unit's staff would co-operate intimately with the staffs of Mental Hospitals, Colonies and Certified Institutions of the region and with voluntary organizations concerned with mental health or mental after-care. One of the unit's chief responsibilities would be to increase the efficiency of the region's psychiatric services. The unit's interests and co-operativeness should be catholic within the region and its junior staff might be shared or interchangeable (perhaps on a part-time basis) with those of Mental Hospitals, Colonies and Institutions.

(7) The unit should be the centre and the co-ordinating focus of research in its region. The professor should be a source of ideas and inspiration to the psychiatric services; he should understand the industrial, occupational, social, geographical and genetic features of the area, and should be fertile in ideas as to how these could be further investigated. He should encourage psychiatrists to take higher medical degrees.

(8) Through the Psychiatric Unit of a provincial University would pass, in the course of their qualifying studies, all the medical students of that University. London University would doubtless be served by several units. The staff of the unit should aim at attracting into the specialty keen and able students with active clinical interests. The senior staff of the unit might be asked by the Faculty to interview candidates for the medical school; they might advise on problems of 'further education' (White Paper on Educational Reconstruction,

paras. 63, 98 and 99). By encouragement here and discouragement there, they might steer into the medical profession and into the specialty of psychiatry suitable types of men and women and keep out unsuitable types. The psychiatric services of the future will depend much on the young men and women who are to-day recruited into their fold.

CHAPTER VIII

TRAINING AND REGISTRATION OF MENTAL NURSES

UPON the vexed question of the selection and training of mental nurses the future development of the country's psychiatric services will depend almost as much as upon the future equipment and quality of psychiatrists. Indeed, the importance of this matter can hardly be exaggerated. It has received, and is receiving, careful consideration by the Athlone and Rushcliffe Committees respectively, which are concerned with problems confronting the nursing profession.

There is general agreement that the status of the mental nurse should be improved; that the conditions of mental should be raised to the same level as those of general nursing; that the position as to examinations should be clarified: and that the 'double' training of mental nurses should be facilitated.

But these matters formed no part of the neurosis survey, and I have nothing new to say on them. I can therefore do no more than point to their urgency and recommend that, after appropriate consideration by all the professional bodies and other organizations concerned, new policies be adopted. If the matter cannot be examined in its full context under the terms of reference of the Rushcliffe Committee (which is concerned with scales of payment for nurses), attention might be given to the recommendations, hitherto unpublished, of the Athlone Committee.

CHAPTER IX

CHILDREN'S SERVICES

It is impossible to make proposals for reorganizing the psychiatric services such as will take fullest account of prevention, without transgressing the bounds of psychiatry and even of medicine. This situation becomes especially clear when we consider the problems of the child. The early detection of sub- and abnormalities such as would be likely to lead to maladjustment is a task for the Education rather than the Health Services.

The neurosis survey has shown that there exists throughout much of the country, prejudices against psychiatry; also that there are marked regional inequalities not only in the provision of psychiatric services for adults but also in the use that is made of such services as already exist. Thus Table XVII (p. 47) shows that over a third of 123 'known' clinics outside London received less than one new patient per session, and that over three-quarters of these 'known' clinics received less than two new patients per session. This situation suggests that there is in the provinces a fairly widespread disinclination to utilize the psychiatric services which already exist. What are the causes of this inertia?

There is little doubt that the main cause is a failure on the part of many general practitioners to appreciate the character of these services (see pp. 14–15). This attitude is partly due to an unawareness of the nature and prevalence of neurosis; but it is also due to a widespread mistrust of psychiatry and to doubts as to its methods of dealing with neurosis. These misgivings are largely focused on analytic procedures. These, it is alleged, take too long to produce results which, at best, are dubious; they are unhealthily preoccupied with matters of sex; they induce introspective habits and focus the patient's attention on his morbid emotions which he should try to forget; they foster malingering and weakness by encouraging people to make a fuss about troubles which should be quietly endured; they tackle the problems of mental illness in the wrong way by seeking recondite causes in envies, aggressiveness, repressions, fixations, etc., while overlooking remediable current stresses and worries; valuable time is wasted by psychotherapists on chronic neurotics and psychopaths who are unhelpable, while the needs of the average normal member of society pass unrecognized. Analytic methods of psychotherapy are sometimes spoken of as if they were a decadent and modern fad.

It is needless to say that these opinions are largely ill-founded. The plain fact is that they exist much more widely than most psychiatrists realize. I have come across them in all parts of the country from laymen and doctors alike, most frequently from persons holding administrative posts. So prevalent, though locally variable, are these views that they are likely, in my opinion, to obstruct the co-

ordination of the country's psychiatric services in any future scheme designed to provide minimum standards.

These prejudices cannot be swept aside and ignored. They will have to be outgrown or replaced by first-hand experience of their inapplicability to the kind of psychiatric service which is contemplated. How can the ground be best prepared for this change of standpoint ?

I suggest that the answer to this question is to be found in the needs of children and juveniles to which priority is given in this report. Several reasons can be advanced for this view, which are founded both on general principles and on immediate expediency.

(*a*) The problem of juvenile delinquency during the war has attracted attention. It is much more widely recognized than the problem of neurosis among adults which, it may be truly said, has been conspicuous by its small dimensions. And apart from delinquency, children have presented problems of adjustment after evacuation. These difficulties have drawn attention to the bad conditions under which many children live in the intimacy of their homes. The light thus shed on places which before were dark has strengthened the case for nursery schools and for child guidance services.

(*b*) Again *via* the problem of delinquency, attention has been drawn to the prevalence among children of dullness and backwardness. The early detection of these cases and their appropriate training and disposal would, in a double sense, serve a valuable prophylactic purpose. They would forestall much delinquency, which is regarded as in part the result of a desire, natural in dull and backward children, to get even with a society which has made them painfully conscious of their shortcomings. But consciousness of inadequacy not only expresses itself in delinquency ; it can also be revealed as neurosis. If we think of neurosis in terms of a simple and on the whole acceptable psychopathology, *i.e.* in terms of maladjustment, it will be clear that there is no more ubiquitous cause of social maladjustment than dullness and backwardness. Here, moreover, is something which can be detected early and appropriately catered for. Every local authority has to deal with children, and every authority is aware of the problem of the dull and backward as well as of the difficult child. It has been brought out in the survey that this problem presents itself (sometimes with especial force) in the most isolated of rural districts where overt neurosis is little recognized. The problems arising from delinquency and of dullness in children are everywhere appreciated in a way that those now presented by neurosis among adult civilians are not. And unlike the latter, they are recognized as subject to prophylactic handling. An organized effort to tackle these problems would accord with well-grounded and widely accepted beliefs about prevention and early treatment.

(*c*) It is now recognized that the effective treatment of neurosis and the efficient conduct of a psychiatric clinic depend on what are called the accessory psychiatric services. Among these the psychiatric social worker takes first place. The survey has shown how widespread is the need for more psychiatric social workers. Not only does this

officer help in making an appropriate disposal of the patient; by clarifying his family occupational background, she also facilitates the diagnosis. She is the link between psychiatry and social medicine. She can make known in an area the services supplied by a psychiatric clinic, and can establish the liaisons which will convert a soporific fortnightly or monthly session, which is barely sustaining itself into a flourishing weekly or bi-weekly affair which is recognized and appreciated by all concerned. The observation quoted on page 71 was made by a psychiatrist on one of the questionnaires used in the neurosis survey. It is relevant here. The clinic in question held monthly sessions.

Now it is possible, as the survey has shown, to run a clinic for adults without a psychiatric social worker. Less than a third of all 'known' clinics outside London (Table XI, p. 142) had the services of such a worker. But for a clinic which is concerned with children, this officer is well-nigh indispensable. A good case can therefore be put forward for making a start in an area with a children's clinic to which is attached a psychiatric social worker. Different sessions in the same premises for adults could then be arranged as their usefulness was recognized and the patients came forward.

(*d*) A somewhat similar argument can be put forward in respect of the *buildings* in which the clinic is accommodated. The survey has shown that many clinics are working in unsatisfactory premises —an inconvenience which is sometimes but not always due to the effects of the war. New buildings may later be erected to provide the necessary out-patient facilities.

In order to deal effectively with children and with the accessory services which they demand, larger and more modernized premises are needed than for adults. Out-patient departments constructed to meet the needs of a psychiatric clinic for children would provide ample accommodation for adults who would be seen at different times, and they would have comforts and amenities which might not be deemed necessary in a clinic limited to adults.

(*e*) For dealing with evacuated children who present difficulties, various hostels have, since the beginning of the war, been established throughout the country. In these, valuable work has been done and useful experience gained. Here are the beginnings of an organization for the residential care of maladjusted children—an organization which the Feversham Committee described as a necessary and logical extension of the child guidance movement. The Feversham Committee says:

> 'In many cases of maladjustment it is possible by skilled guidance to restore the normal balance; but where an adverse environment cannot be modified, out-patient treatment is pitted against overwhelming odds. In such cases removal to new surroundings offers the only hope of successful treatment.'

The war-time hostels are emergency measures taken to meet war needs; but they have been so useful that they deserve to be perpetuated under appropriate psychiatric supervision after the war.

Attention was drawn above to prejudices against certain psychotherapeutic methods when applied to adults. Prejudices also exist against child guidance. This is said to be an American fad, that it consists in making a big fuss over spoiled 'problem' children who need, not guidance by a whole team of adults, but a sound spanking, etc. But these sentiments are less marked than those directed against the analytic treatment of adult neurotics. And they have been seriously weakened by the obtrusive problems of child evacuation and delinquency. There are clear signs of a growing sense of communal responsibility for children and dependants; there is a demand, reflected in the Education Act, that they should be better taught than in the past, and given better chances in life than their fathers. Nursery schools, family allowances, better recreational opportunities are demanded as well as better education. And to the prickings of social conscience are now added the incentives of a positive population policy.

How, then, should psychiatric services for children be organized?

A general answer to this question can be found in a co-ordination of the education with the mental health services such as will bring about early detection and sub- and abnormalities in children and provide appropriate educational facilities and treatment. A valuable lead is given by the White Paper, 'Educational Reconstruction', Cmd. 6458, and by the Education Act.

The following is an outline of the educational periods as now envisaged:

Age 2–5	Nursery School	Non-compulsory.
,, 5–7	Infant School	Primary Education; Compulsory and free.
,, 7–11	Junior School	
,, 11–15 or 16	Grammar or Modern or Technical School	Secondary education; Compulsory; Free.
,, 15 or 16 to 18	County Colleges	Further Education Compulsory, part-time and free.
,, over 18	Adult Education	Non-compulsory.

The White Paper further proposes to classify children of eleven when they pass from Primary to Secondary education—

'not on the results of a competitive test, but on an assessment of their individual aptitudes largely by such means as school records, supplemented, if necessary, by intelligence tests, due regard being had to their parents' wishes and the careers they have in mind' (para. 27).

According to this arrangement, a decision of momentous importance for the subsequent life of the child will be taken at the early age of eleven. The nature will be decided of the secondary education which he will receive. He will be placed on one of three possible roads which will lead to his later career as an adult. The supplementary use of intelligence tests to the school record, in the place of a competitive examination, is recognized.

The part which intelligence tests can play should be neither under-

estimated nor exaggerated. They should not be regarded as providing better means of assessing a child's aptitudes and personality than the unaided opinion of the school teacher who has had opportunities of observing the child over a long period. But they can provide valuable confirmation of the teacher's conclusions, and can sometimes draw attention to potentialities in the child which are not clearly disclosed by his school record. In particular, they can suggest that certain children have better intelligences than are suggested by their school work.

The proposal of the White Paper that the school records be supplemented, if necessary, by intelligence tests has important implications. It calls for the establishment, under the Education Authorities, of an organized psychological service whose help can be drawn upon when necessary. And it implies a close co-operation between teachers and psychologists. It has been suggested by Dr. C. J. C. Earl that, at three periods in his educational career, the child should take part in a group test. These group tests could probably be administered by the teachers, many of whom have knowledge of psychological methods. The chief object of these tests would be to draw attention to children at the extremes of the scale of intelligence—say, the 5 per cent most intelligent and the 10 per cent least intelligent children. For both of these groups special provision may be desirable, for they include the children least likely to benefit from the normal educational curriculum. The Wood Committee (1929) has drawn attention to the presence in the community of a higher proportion of feeble-minded children than are in fact ascertained. Such children are a drag on the normal class, and are often made painfully conscious of their shortcomings. Recent experience has shown that dull children drift more easily than others into juvenile delinquency. It is clearly desirable that the innate disabilities of these children should be recognized at the earliest moment, and that their educational curriculum should be suited to their limitations. Conversely, those children at the other end of the scale, whose intelligence is above the average, are apt to be held back in the ordinary class where they are bored and feel restricted. They might benefit from special educational opportunities, and they form part of the group for whom a university education would later be appropriate. They constitute the nation's most valuable assets, and full scope should be given to them from the start to develop their full potentialities. Another group of children to whom attention might well be drawn in these tests are those whose intelligence is in excess of their school performance. Such children benefit much from what has been called remedial teaching, to which reference will be made later.

The three stages at which these group tests might be given would require to be carefully considered. The ages of seven, at the transition from infant to junior school, of eleven at the end of primary education, and at fifteen or sixteen, when compulsory secondary education ends, might be appropriate.

The children screened from the bulk by these tests would receive individual tests, either from a school teacher or a psychologist. The latter, at the child's school-leaving, might also give vocational tests;

and she would be available to advise on children who presented problems or difficulties to the teacher.

The psychologist who worked under the Education Authority would therefore have as her main duties to assist, if needed, school teachers in administering group tests (if these come to be used); to examine by means of individual tests children separated from the bulk by the group tests, and also children who present problems of behaviour or who are a source of worry or anxiety to the school teacher or the school medical officer: and to advise on problems of 'further education', perhaps helping with vocational guidance. She might also undertake remedial teaching of children whose school records do not do justice to their real abilities and where the backwardness seems to be connected with specific psychological factors. These have been described as 'children of unfulfilled promise'. Such work is undertaken by psychologists at some child guidance clinics, as at the Hill End clinic, where satisfactory results have been reported in selected cases.

According to some such arrangement, the pupil would be kept under continuous psychological observation throughout his school life.

The feeble-minded, the dull and the backward would be detected early, receiving full investigation and. if he needed, disposal; the ascertainment of children who were defective by the standards of the Mental Deficiency Act would be facilitated and brought nearer the desired level: the able child whose full resources were not being developed by the ordinary curriculum would be spotted; and lastly, difficult and problem children would be further investigated and referred, if need be, to the child guidance services. Many of these suggestions are not new. Educational psychologists have been increasingly employed by Local Education Authorities for some years past for work of this nature. Moreover the Education Act by its insistence in Section 34 on the ascertainment of all children suffering from disability of mind or body should result in the discovery of dull or backward or problem children at an early age, and secure their disposal in special schools of various types suited to their several needs.

How, then, would the medical services come into this picture?

There has been some controversy as to what authority should be responsible for the child guidance services. They are at present provided under:

(i) Voluntary organizations.
(ii) Education committees.
(iii) Public Health committees.
(iv) Psychiatric services (visiting committees).

It has further been suggested that they be established under

(v) Paediatric services.

The White Paper, 'Educational Reconstruction', has an important passage (para. 94) which reads:

'When this stage (*i.e.* the setting up of comprehensive medical services) is reached, it will no longer be necessary for local Education Authorities

to provide *treatment*, and their functions will be confined to providing medical inspection and seeing that the children and parents are properly advised and encouraged to seek, through *the new health channels*, any treatment the child may need." [My italics.]

The distinction between inspection and treatment (also stressed in the White Paper on the Health Services, page 39) is not brought out so clearly in the Education Act as in the White Paper; and it seems likely that local Education Authorities will have to continue to provide many forms of treatment for some time to come: but it is probable that, when the comprehensive health services are set up, the health authorities will be mainly responsible for providing treatment.

That the duties of child guidance might be divided between the Education and Health Services was suggested by the Feversham Committee (paras. 431 and 432), whose proposal deserves further consideration. This Committee suggested that Education Authorities should concern themselves with those problems of child guidance which are mainly *scholastic* in character—including the ascertainment and disposal of defective, dull and backward types; within the province of the Health Authorities, on the other hand, would be comprised problems of abnormal *behaviour* (including delinquency), which call for treatment. No hard-and-fast line can be drawn between these two classes, but they are generally distinguishable. The treatment needed might turn out to be psychological or physical: hence the importance of clinics working under the Health Authorities being placed in close relation to hospitals (if possible those containing paediatric departments) wherein full physical investigations can be carried out.

The Ministry of Education have decided to call the first type of place, established under the Education Authority, a *Child Guidance Centre*; and the second, incorporated in the Health Service, a *Child Psychiatric Clinic*. The former, the Child Guidance Centre, might appropriately be the headquarters of the psychologist working under the Education Authority. In a densely populated and geographically compact district, with good transport facilities, the Child Guidance Centre would be easily accessible to all the children in the area, and frequent sessions could be held. Some, but not all, of these should be attended by a psychiatrist based on a Child Psychiatric Clinic. At the Child Guidance Centre, the psychiatrist would examine and perhaps treat such cases as were referred to him by the psychologist or the school medical officer. A proportion of these children might be sent to the psychiatrist by a system of 'automatic referrals' such as is used for intakes into the Army—*i.e.* all stammerers, bed-wetters, etc. The psychiatrist would at the 'centre' pick out the cases which he felt needed special treatment; he could either treat them on this spot or, if convenient, could refer them to the Child Psychiatric Clinic, where they might be more appropriately dealt with. In an area with a scattered population and poor transport facilities, the psychologist's work would be largely peripatetic; she would hold sessions in different places—usually at or near schools. The attendance of the psychiatrist would be adapted to the circumstances.

The Child Psychiatric Clinic belonging to the health services would form part of a central psychiatric clinic (Chapter XI (4); p. 75) which would be a constituent element of a key, perhaps of a teaching, hospital with a paediatric department. The Child Psychiatric Clinic would be equipped with a full psychiatric team and would have facilities both for play therapy and for the treatment of adults—an important feature since much child psychiatry consists in advising or treating the parents. To the Child Psychiatric Clinic would be referred not only children seen at the Child Guidance Centres; the 'clinic' would also receive children sent direct by doctors—general practitioners in the area and the psychiatrist's hospital colleagues—magistrates, probation officers, etc. Such direct referrals should not cause difficulties provided that the school medical officer were notified of the cases seen.

It is not easy to distinguish rigidly from one another the functions of the Child Guidance Centre and the Child Psychiatric Clinic, though a general idea of the difference is implied in the terms 'Guidance' and 'Psychiatric'. The problems dealt with by the Child Guidance Centre would be mainly of a kind that permit of rapid and simple adjustment, often of a scholastic nature, after an assessment had been made of the child's aptitudes and limitations.

The type of case referred to the Child Psychiatric Clinic, on the other hand, will require therapy. Repeated attendances will be called for, taking up much staff time; these would be facilitated by the existence of a hostel to which children could be temporarily admitted, in close proximity to the clinic (see Chapter XI (5), p. 76).

The difference in question is generally similar to that between the spheres of the psychologist and psychiatrist. Indeed, a general division of the functions of these two is called for by the allocation of duties between the 'Centre' and the 'Clinic'. The administrative arrangements would need to be flexible, and different adjustments would be required in different areas depending on the numbers and distribution of the population and the transport facilities. With experience, it should be realized that the psychologist and the child psychiatrist are supplementary to each other, and that the one cannot properly do his work without the other. The survey has revealed more instances of happy and harmonious co-operation than it has of friction. There are good reasons for hoping that the experience of the majority will soon become the rule.

The numbers of centres and clinics suggested for a population of a million are discussed in Chapter XI, pp. 73–76.

CHAPTER X

THE RÔLE OF THE MENTAL HOSPITAL IN A MENTAL HEALTH SERVICE

If the somewhat narrow conception of the bounds of institutional psychiatry (as limited to the psychoses and mental defect) which has existed in the past and, in certain quarters, still seems to exist is to be widened, if in the future a closer link is to be forged between psychiatry and general medicine, and if the responsibilities of what amounts to a psychiatric social service are to be undertaken—then the question is raised as to what part the Mental Hospital is to play in the new spheres. It will be contended in this chapter that we should do well, in future, to think and speak in terms of a Mental *Health* rather than of a Mental *Hospital* Service.

Some people hold the view that the new fields, especially child guidance and industrial medicine, have so little in common with institutional psychiatry that they should be cultivated by other personnel than that provided by the staffs of Mental Hospitals—*i.e.* by a service of so-called medical psychologists. This is a retrograde proposal running counter to the beneficent trends started by the Mental Treatment Act. Since this Act was passed in 1930, Mental Hospitals have undertaken wide extra-mural services. Of the 216 psychiatric clinics covered by the neurosis survey, 150, or nearly 70 per cent, were staffed by psychiatrists based on Mental Hospitals; and of the 148 known clinics founded after 1929, 113 (over 75 per cent) were thus staffed (Table XXXVIII, p. 177). Several Mental Hospitals, moreover, undertake child guidance with their other extra-mural work. There is now an active child guidance section of the Royal Medico-Psychological Association.

But the Mental Hospital services must be more generously staffed and better equipped for the new work. If they are not reorganized so as to attract good men trained in a catholic psychiatry, the outside work may be undertaken by men and women who have designedly remained outside these services: an unfortunate dichotomy will be produced inside the specialty, and the Mental Hospitals will be further 'immured'. The strengthening of the Mental Hospital services is an essential reform.

Changes are desirable in three directions:

(*a*) Closer links should be established with General Hospitals. Indeed, the mental health services of the future should be jointly administered by General and Mental Hospitals. The non-teaching psychiatric units described below (p. 67) are visualized as being thus jointly provided. Outside London, psychiatric clinics in General Hospitals, both Voluntary and Municipal, are widely staffed by Psychiatrists based on Mental Hospitals; this position arises from the fact that, in the provinces, there are few psychiatrists in consulting practice who are not engaged in these services. Little change is to be

expected in this arrangement, which does much to mitigate the isolation of the Mental Hospital; for the latter is divested of many of its terrors when it is realized that the doctor whom the patient has seen at the out-patient clinic is the one who will continue to treat him in the hospital. The recognition, moreover, of the prevalence of what are nowadays called psychosomatic illnesses or, in simpler language, of the rôle played by the mind in physical disease, has resulted in the permeation of general medicine by psychiatry. From another aspect, the same recognition has led to the plea that more attention should be paid to psychiatry in the curriculum of every medical student. Mental diseases are no longer regarded as forming an isolated group, dealt with in special manuals and hospitals, and omitted for convenience from the text-books of general medicine. The mind and body together make a unity: disturbances of the one affect the other, and neither can be ignored by the doctor.

(*b*) Part-time service should be allowed in Mental Hospitals. Such an arrangement could be varied to meet many different needs; and it might include both in-patient and out-patient work. By such means, much light and air would be let into spaces which, in the past, have been confined. The Voluntary and especially the Teaching Hospitals provide varied and instructive examples of how successfully part-time arrangements can be made to work. The system is one in which almost every member of the staff, from the senior physician or surgeon to the junior registrar, can participate: indeed, the only medical personages outside its orbit are the house officers, whose tenure of whole-time office is limited to a few months, and sometimes the superintendent. The part-time system applies to in-patient work alone, to out-patient work alone, and to both at the same time. The senior members of the staff may have many beds, but frequently do no out-patient work; assistant surgeons and physicians as well as specialists may have fewer beds and also see out-patients; the registrars help with both in-patient and out-patient work: and many out-patient departments have assistants who have neither duties nor responsibilities in the wards. Yet the hospital retains an organic unity and a corporate spirit of its own; its atmosphere is open and happy; and the patients get the best possible treatment. The fact should not be overlooked that the essential and indispensable machinery, which must be always on the spot and always working, is provided by the nursing staff.

How far could these varied and elastic arrangements be adopted in a Mental Hospital? I do not feel competent to answer this question, which should receive careful examination by persons with the necessary administrative experience. But it would be both useful and appropriate if the Royal Medico-Psychological Association were to draw up a list of approved part-time arrangements which superintendents of Mental Hospitals could put up to their Visiting Committees. The scales of payment would depend on the qualifications, experience and status of the doctors concerned and on the amount of time they gave to the work. Many people think that the senior clinical posts in the hospital should be part-time. And part-time work might be done under the Medical Officer of Mental Health (Chapter XII, pp. 86–90).

(*c*) The mental hospital services should offer better prospects for clinicians. At present, the goal of most entrants into these services is to become a superintendent. While the work of a superintendent is largely what he makes it, this officer is unavoidably concerned with problems of administration and with his relations to his Visiting Committee. These preoccupations, which sit lightly on the shoulders of most superintendents, are not always welcomed by men whose ambitions and interests are in clinical directions. Such men may be deterred by prospects, which in the longest view seem unattractive, from ever entering the Mental Hospital Service; or, having entered, they may be tempted to leave it for more congenial pastures.

The possibilities of part-time work would do much to make the mental hospital services more alluring; in particular, they might draw more women who have a valuable part to play in the child guidance movement. An arrangement might be reached whereby the highest clinical posts were part-time, the work being divided between the Mental Hospital and a Psychiatric Unit. The salaries of such senior and part-time men might be on the same proportional level as that of the superintendent, thereby holding out attractions for the men whose main interests were clinical. The Army distinguishes between men who are 'G' minded and those who are 'Q' minded, the latter having a bent towards problems of routine administration, organization and supply. A similar distinction has been discerned among business men, and may exist in other professions, that of the doctor among them. Men with an aptitude for administration find plenty of scope in the medical profession, and are likely to find still more in the future. Yet the encouragement of men with clinical interests and of men anxious to do research is one of the foremost problems confronting the profession. The paths of these should be made easy, and nothing should be done to interfere with their scientific freedom nor with their right to publish. The part-time system might here prove valuable.

There are five main directions into which the mental health services of the community might develop outside the Mental Hospitals.

1. Out-Patient Departments for Neurosis and Early Psychoses.

It has already been remarked that as many as 150 of the 216 psychiatric clinics covered by the survey were staffed by psychiatrists based on Mental Hospitals. But many of these clinics might be more active. The survey showed (Chapter XVII, pp. 176–183) that psychiatric clinics staffed by psychiatrists from these hospitals (called 'M' clinics) were, as a class, established later than those otherwise staffed ('O' clinics), that they held less frequent sessions, handled fewer new patients at the average clinic-session, saw fewer return cases and dealt with a smaller proportion of neurotics. These differences are largely accounted for by the fact that a large proportion of the 'M' group clinics were established after 1929 in the smaller centres of population which are psychiatrically backward. The survey further revealed two

important trends among the small-town clinics of which the great majority (68 out of 77) were staffed by psychiatrists based on Mental Hospitals. These trends were that, throughout the four years covered by the survey, increasing numbers of new patients were seen at the average clinic-session, and that an increasing proportion of these patients were diagnosed as neurotic. While these changes may be partly due to the effects of evacuation, it is also possible that they may reflect an increasing degree of psychiatric enlightenment in less urbanized areas, and a widening awareness among general practitioners of the services which the clinics can give. These trends, whatever their interpretation, are encouraging signs, and they should be watched in the post-war years. Every effort, moreover, should be given to assist them. We may hope that the time will come when there will remain few differences between the two types of clinics; they should be equally attended by early cases, and equally equipped to undertake treatment. The help of accessory personnel is here indispensable, particularly for making known throughout the area what services the psychiatric clinic can give.

In adapting their clinics to the reception of early cases and to the treatment of neurosis, full use will doubtless be made by the Mental Hospitals of such post-graduate facilities as may be offered by Teaching Psychiatric Units. Here much could be learned through post-graduate attachments and refresher courses.

The psychiatric clinic should be regarded as a centre of social psychiatry rather than as a place with purely medical functions. A government department may want an opinion on a compensation case: how much is the present disability really attributable to the injury? A report on the man's mental state and history may be as important as an opinion on his physical condition. A general practitioner may be puzzled as to how far psychological factors play a part in the symptoms complained of by a patient. The superintendent of a Mental Hospital may want a patient discharged as recovered to be kept for a time under observation. The Medical Officer of a factory may be concerned about the mental state of an operative who has been repeatedly absent. The Regimental Medical Officer of a neighbouring unit may want an opinion on a doubtful case. So may an official at an employment exchange. Vocational or forensic advice may be sought. Various voluntary or charitable organizations may have similar problems. The White Paper on Social Insurance announces that a Minister of Social Insurance is to be appointed and that a wide network of local offices will be established at which the public may lodge claims, seek information or guidance and obtain payment for certain benefits. These local offices will be confronted with some difficult problems, and may be glad to make use of a well-organized psychiatric service. A magistrate may be doubtful about the mental condition of a person charged with some offence; is he to be regarded as of normal mentality? A Probation Officer may be in a similar uncertainty about a juvenile or young adult committed to him for supervision. All too often there is no recognized authority to whom such awkward cases can be referred for an expert opinion

A properly organized and equipped psychiatric service can fill these and other needs.

2. Child Guidance Services.

These services were first put on their feet through American example and munificence; and they have developed in comparative independence of the mental hospital services. Of 95 child guidance clinics of which particulars were available in February 1944,[1] 8 were closed. Of the remaining 87 clinics, only 25 included on their medical staff psychiatrists then engaged in the mental hospital service. At present it is the exception rather than the rule that the superintendent of a Mental Hospital takes an active interest in child guidance; but where this is done, the results are gratifying. The population of the area loses much of its fear of the Mental Hospital, and the value of the work is quickly recognized by visiting committees. Child guidance should take a prominent place in the mental health services and the staffs of Mental Hospitals should give to the subject all possible attention. The staffs of Certified Institutions should also take an active part.

3. Occupational and Industrial Psychiatry.

The difficulties of placing in suitable employment persons suffering from psychiatric disabilities have been officially recognized. Ministry of Health Circular 24A '44, dated 6th April 1944, contains the following passage:

> 'The Ministry of Labour and National Service consider that the advice of a skilled psychiatrist would be most helpful to officers at Employment Exchanges in determining whether a worker known to be suffering from psychoneurosis or psychosis is, in fact, suitable for employment and, if so, what type of employment he or she is best fitted to undertake.'

Difficulties of placement have presented themselves during the war. They will be aggravated when, on a large scale, the Armed Forces are demobilized and prisoners of war repatriated. The psychiatrist may be expected to decide upon complex problems of disposal when there are several alternatives. Some men, while continuing at work, could attend a psychiatric clinic; others might benefit from a period of rest and recuperation at a place resembling the existing rest-break centre, where there is no medical supervision and no organized activities; others will do better at a place where organized work of various kinds alternates with periods of relaxation; others will need a course of specific vocational training and rehabilitation.

Decisions as to which of these measures is appropriate call for a knowledge both of psychiatry and of industrial life. The Industrial Medical Officer will, in most cases, have the requisite knowledge and will solve his problems unaided. Sometimes he will ask for the psychiatrist's help. The latter should then be familiar with the organization of a factory and with the main industrial concerns in

[1] See Appendix V (pp. 195–199).

his area. The Army has recognized how important it is that the military psychiatrist should know something of the soldier's life; for their own educational benefit, some have apprenticed themselves for a period in the soldier's routine duties. Similar principles apply to the relation between the civilian psychiatrist practising in an industrial area and the industrial worker.

Regular visits by a peripatetic team to certain large factories or industrial centres may, now and then, be needed. These might be organized by the Medical Officer of Mental Health. Again the Teaching Psychiatric Unit should provide an introduction to the subject.

4. Delinquency and Criminal Psychiatry.

Cases of juvenile delinquency will doubtless be dealt with by the child guidance services. The psychiatric approach to the adult criminal has certain features of its own for which special training is needed. Two problems may be singled out—namely, whether a prisoner is responsible for his actions, and the selection of prisoners for psychotherapy. A sentimental or biased approach to these issues on the part of doctors no less than of magistrates can result in disastrous precedents being set.

If serious mistakes are to be avoided, long experience is needed of the special features which differentiate criminal from ordinary psychiatry. The average neurotic patient suffers from various mental stresses and personal inconveniences of which he wants to be rid. There may be unconscious attachments to symptoms and obscure motivations for illness; but the conscious attitude is usually straightforward. Not so with the prisoner, whose relation to the doctor is distorted by oblique and ulterior motives. Hence decisions as to the criminal responsibility and the suitability for psychotherapy of prisoners should be left to the prison Medical Officer, who has the necessary background of experience. But psychotherapy for cases deemed suitable by the prison M.O. could usefully be provided by the area psychiatric service, either by a visiting psychotherapist holding regular sessions at the prison or by other arrangements. Close consultation should be maintained with the prison M.O., who should receive regular progress reports and have power to terminate the treatment.

The services of psychiatrists on an area or regional basis might also be useful in connection with Remand Centres, Prison Remand Homes, Compulsory Attendance Centres and Howard Houses, which are proposed in the Criminal Justice Bill, 1939. They might also be helpful under clause 19 of the Bill, according to which a Probation Officer may require that offenders who are not certifiable as insane or mentally defective should submit themselves to mental treatment either as out- or in-patients; and under clause 38, according to which the Court may remand an offender on bail with a requirement that he subject himself to medical examination.

Here are useful opportunities for social psychiatry. They might well be recognized by the mental hospital services, and steps should

be taken to see that, in each Mental Hospital and in each Joint Authority area, there were men with the necessary training and experience.

5. Rehabilitation Centres.

The subject of rehabilitation, raised in Assumption B of the Beveridge Report, was discussed in detail by the Tomlinson Committee (Cmd. 6415), which recognized that the psychiatric patient presents problems of his own. In a national rehabilitation service organized on an area or regional basis, there may be more than one arrangement : in some places the psychiatric patient may be rehabilitated with patients suffering from physical disabilities ; in others, he may be segregated in special centres. The subject needs to be further discussed. An acceptable solution might be found in an arrangement by which the majority of psychiatric cases were rehabilitated with medical and surgical cases ; but a small number of special centres might be set up for severe cases who would not benefit from the methods of the average physical centre and who would have a bad effect in such a place. Such special rehabilitation centres might have features in common with the neurosis centres which are now working under the E.M.S. ; and they might appropriately be placed near a Teaching or Non-Teaching Psychiatric Unit.

Here are five ways in which the mental health services of the future might develop outside the Mental Hospitals. In all of them the staffs of these hospitals should play their part. The Teaching Psychiatric Unit of the area should provide the needed training, and it should be able to improve its teaching methods by using its erstwhile pupils and by building on their experience.

CHAPTER XI

PROPOSED MENTAL HEALTH SERVICES FOR A POPULATION OF A MILLION

THE White Paper on the Health Services recommends that provision for mental health in all its aspects should be the responsibility of the Joint Health Authorities. Of these, there might be between 30 and 35 in England and Wales, with their population of about 40 millions. The average population of a Joint Authority area would therefore be about one and a quarter millions; but the actual range might be from 500,000 to 4 millions.

A convenient way of considering future needs will therefore be in terms of a unit of population of a million; appropriate corrections can easily be made for figures above and below this average.

SUMMARY OF PROPOSALS

The contents of this chapter have been summarized on pages xx–xxi.

1. In-Patient Accommodation outside Mental Hospitals: Psychiatric Units.

In Table XXXV (p. 174) are shown the survey's findings as to the number of psychiatrists in charge of clinics who thought that more in-patient accommodation for early and remediable cases was needed.

There were 121 out of a possible 169 advocates of this development. But nobody has made concrete proposals as to the scale on which the new provision should be made. This is a difficult matter on which to submit definite proposals, and there is little in past experience to draw upon for guidance.

The first question which arises is whether the new beds should be located inside or outside Mental Hospitals.

Though public opinion has been enlightened during the last fourteen years by the Mental Treatment Act and by the efforts of voluntary societies, there still remains in most parts of the country a fear of what used to be called lunacy and the lunatic asylum. That it is possible so to educate a local population as to remove this fear, is shown by what has been done by certain enterprising superintendents. A notable example is St. James' Mental Hospital, Portsmouth. Here out-patient sessions are attended by all social and diagnostic classes with as little qualms as might be provoked by a visit to a Voluntary Hospital; here, without an afterthought, parents bring their children for advice and guidance. If the inhabitants of England and Wales as a whole were as advanced in their ideas as are the general practitioners and population of Portsmouth, there would be little need to establish Psychiatric Units outside of Mental Hospitals as part of a mental health service.

But unfortunately public opinion in the country as a whole is not so far advanced as in these selected places. It would be a mistake to try and force changes in this matter and to dismiss as negligible fears which, while partly the expression of natural reactions, are also rooted in the superstitions of a bygone age. For this and other reasons, a small number of beds should be made available for early and remediable cases, mainly neuroses, in or closely associated with General Hospitals.

But on what scale should these beds be provided ? In the survey of hospital services carried out during the war by the Nuffield Provincial Hospitals Trust and by the Ministry of Health, an inquiry was made as to the number of beds reserved for psychiatric cases in General Hospitals (Voluntary and Municipal) and in Public Assistance Institutions. The results do not carry us far, because the figures do not show for what special purposes these psychiatric beds were used : those reserved for observation are pooled in the returns with those occupied by mental defectives and by senile dements. It is impossible to conclude how many beds are available and habitually used for early and remediable cases.

The proposals which follow may appear to some as unduly modest. They are submitted in the belief that it is advisable, in the early stages of new developments, to make small beginnings which can later be expanded in the light of experience and (if it is achieved) success. There are reasons, furthermore, for caution in providing special beds which will be largely used for neurotics.

Such beds, however numerous, tend to get filled to capacity from the large reservoir of neurotic cases undergoing treatment. A slight lowering of the standards of admission can result in a large increase in the number of patients regarded as admissible ; and there is a danger of in-patient facilities being abused as an easy way of disposing of awkward or problem cases, especially of chronic neurotics. In-patient treatment is only rarely necessary for neurotics, who are better dealt with as out-patients. In the early stages, moreover, there will be difficulties in securing adequate staff.

For these reasons, it is suggested that, for a start and as a minimum, beds be provided outside Mental Hospitals, for such early and remediable psychiatric cases as do not go straight into an admission unit of a Mental Hospital, at the rate of 100 *beds per million of population, or* 0·1 *per thousand.* This rate is less than a thirtieth—between 2 and 3 per cent—of the provision necessary for patients in Mental Hospitals. It would imply establishing 4000 such beds for the population of 40 millions in England and Wales.

The above recommendation is of a general character, and is intended as the foundation of a plan which should be extended if experience shows it to be successful. It is not proposed as an inflexible rule applicable in every administrative area irrespective of the provision made by neighbouring authorities. Administrative areas will presumably vary much in size and character, and some will include more rural and thinly populated districts than others. About 12 of some 30 or 35 areas will contain University towns, some with Teaching

Psychiatric Units; and areas will vary much in hospital facilities. The following suggestions must therefore be regarded as in the highest degree elastic; they are, indeed, little more than finger-pointers suggesting how, in an imaginary Joint Authority area, the proposed in-patient facilities might be provided.

ORGANIZATION OF TEACHING PSYCHIATRIC UNIT.

It will be convenient at this stage to consider the structure and accommodation of a Teaching Psychiatric Unit. The possible functions and services of such a unit, under the directorship of a professor of psychiatry, have been considered in Chapter VII (pp. 42–45).

The unit should be located and built so as to combine the best teaching facilities with the most favourable conditions for the treatment and recovery of patients. The arrangements here described are based on the designs of various units already in existence, and on the experience of the Board of Control in preparing specifications for Admission and Convalescent Blocks of Mental Hospitals. I am indebted to Mr. F. Coutts Webster, the architect of the Board of Control, for preparing drawings of various types of unit and clinic. These drawings can be seen by interested persons at the Ministry of Health (see Appendix VII).

One plan for a Teaching Psychiatric Unit of 72 beds is drawn on the assumption that the unit is situated on the periphery of a large town and that there is plenty of space for buildings and grounds; another has been prepared for a town site where space is limited. In both plans, the unit consists essentially of 6 wards for adults, 3 for each sex, containing 6 to 15 beds each, as follows:

(*a*) Two small wards of 6 beds for more or less acute cases needing fairly continuous supervision. It is debatable whether these wards should be included in a non-teaching unit; but here they are desirable for teaching purposes.

(*b*) Two wards of 15 beds for less acute cases, not needing so much supervision, but undergoing *active* treatment.

(*c*) Two wards of 15 beds for convalescent and recovering cases who might be allowed certain liberties and privileges.

Also included in the unit are:

(*d*) An out-patient department of the class described in this report as a *central psychiatric clinic* with facilities and accommodation for full accessory and clerical services, a registry for storing records and case-sheets, and such accommodation for children as is proposed for a *Child Psychiatric Clinic* (see Chapter IX, p. 54). The department includes a generous supply of small consulting-rooms wherein student, post-graduate helpers and others can take histories, conduct examinations and practise psychotherapy.

(*e*) A Central Pathological Laboratory, which may fit in appropriately with the mental health services of the area.

The three grades of ward would enable the student to follow a case through to the time of its discharge. They mark the progress of the patient and foster an interest in his recovery by registering the stages therein. The out-patient department should be built on a scale that would admit of teaching: the senior psychiatrist should have a room large enough to contain from a dozen to twenty people—students and others. The question of whether it is desirable to give convulsant therapy to out-patients is still under dispute, and there are divergencies of opinion. If this procedure comes to be regarded as practicable and safe, out-patient departments should have facilities for this work.

Primary importance is attached in this report to child psychiatry. In order that this may be properly taught, good clinical material should be available. There is much to be said for the view that children showing behaviour disorders should not be treated as hospital patients, but should rather be put up in special children's hostels comparable with those which have been established by the Ministry of Health for difficult children as part of their evacuation scheme. Such a hostel, if set up in close association with the teaching unit, would dispense with the necessity of a children's ward in the unit. Arrangements could doubtless be made for training nurses in the hostel. There should be close links with the Department of Paediatrics.

A Teaching Psychiatric Unit of about 70 beds would, according to the rate here proposed, provide in an area of a million population most of the accommodation outside Mental Hospitals for early and remediable psychiatric cases. It is probable, however, that the eleven universities of England and Wales which contain medical schools (Oxford, Cambridge, London, Durham, Manchester, Birmingham, Liverpool, Leeds, Sheffield, Bristol and Cardiff) will serve as centres for populations larger than a million. The population of the administrative area of London, for instance, may be nearer four millions. The needs of areas containing provincial universities might be met either by establishing a unit containing more than seventy beds—the Maudsley Hospital contained, before the war, some 300 beds for adults as well as beds for children—or else by setting up other 'non-teaching' units elsewhere in the area. This will be one of the problems which will confront the new Mental Health Committees and, if the posts are created, the Medical Officers of Mental Health who will be their chief executive officers.

Where should the Teaching Psychiatric Unit be located? There can be little doubt that, from the standpoint of the patients, the best place would be the periphery rather than the centre of a big town, if possible on the edge of a green belt. Here, there would be no sense of confinement; flower and vegetable gardens could be cultivated and there would be facilities for outdoor games and recreations. Much can be learned from some of our Mental Hospitals as to how rural amenities can bring interest and happiness to psychiatric patients. But such an arrangement might be difficult to reconcile with the maintenance of the necessary close relations with the parent teaching hospital of which the Psychiatric Unit should form part. There might also be difficulties about the unit's accessibility to students, teaching

staff and out-patients. These factors will depend on the policy pursued by the teaching hospitals themselves. Problems differing from those of London confront all provincial cities. A twenty-minute bus or tram journey will usually take the resident out of the town into country surroundings; and in London more parks, playgrounds and open spaces are advocated in the new plans. It is to be hoped that full use will be made of these in schemes for hospitals and rehabilitation centres. There has been some discussion of projects according to which a hospital whose main building would be on the periphery of a town might have an out-patient department in the centre, with perhaps a ward for accident cases and other emergencies. Such an arrangement would depend much on facilities of transport, such as a good public bus or tram service supplemented by a hospital ambulance service travelling, say, twice a day.

Facilities for occupational therapy should be available in the unit, and horticultural activities in the grounds provide a useful outlet. Patients from the out-patient department and perhaps from the convalescent wards might be referable to an occupational centre which might usefully form part of a near-by rehabilitation service.

The location of the Teaching Psychiatric Unit would depend much on that of the hospital as a whole of which the unit formed a part. With all the departments of this, the unit should be in the closest relation, but with two the bond should be especially close—the Department of Paediatrics and the Department of Neurology. Arguments as to the desirability of rural surroundings and a country setting apply to the paediatric wards no less than to the psychiatric; and an essential feature of every child psychiatric clinic should be its ready access to paediatric facilities, both diagnostic and therapeutic. The relation of psychiatry to neurology has been much discussed. Weighty support has been given to the view that neurology and psychiatry are so bound up with one another that they should be thought of as a single subject, neuro-psychiatry; and that we should think in terms of neuro-psychiatrists, neuro-psychiatric units and clinics rather than in those of the shorter terminology which is used in this report. Affections of the brain—cerebral tumours, syphilis, epilepsy and head injuries—produce psychiatric manifestations which are as much in the province of the neurologist as of the psychiatrist. The one cannot easily dispense with the help of the other, or if he does, the patient may suffer.

The practical arrangements affecting hospital administration to which these arguments point must be decided in relation to local personalities, feelings and organizations. In certain university medical schools or Joint Authority areas, it may be found desirable to treat neurological and psychiatric cases in the same unit. Under such an arrangement the professor of psychiatry would reach an understanding as to beds and services with his neurologist colleague; and the unit should be equipped as a centre for brain and other neurological surgery. It might be desirable to make it larger than the Psychiatric Unit here described. Such an arrangement has much to recommend it—among other things the close relations established between psychiatry and general medicine.

A final word about the above-mentioned plans. These are made available not in the expectation that they will be approved and adopted as they stand by any university teaching hospital, but because they may prove helpful in showing the physical and structural needs of a unit whose size might be appropriate to an area comprising between one and two million people. Together with the other proposals contained in this section, they are to be taken rather as suggestions or bases for discussion than as detailed specifications.

NON-TEACHING PSYCHIATRIC UNITS.

The majority of administrative areas of the future will not contain a university. For them the question of providing a Teaching Psychiatric Unit will not arise. Beds for psychiatric cases outside Mental Hospitals will have to be provided by the leading General Hospitals of the area.

The problem of where and in what aggregates these beds should be grouped will have to be solved by the responsible authorities in the context of local facilities and conditions. For a population of a million, 100 beds might be provided in two fairly large units containing about 50 patients each, or in more numerous and smaller units. It has been suggested that, in some areas, two wards (one for each sex) containing from 10 to 12 patients would suffice.

A difficulty is presented by the observation ward wherein patients destined for Mental Hospitals are received when immediate disposal is required. This place will presumably disappear (in its present form at least) together with the existing Poor Law. What is to succeed it? And how far should the replacing organization encroach on the suggested provision per million of population of 100 psychiatric beds outside Mental Hospitals?

Two contrasting views may be discerned, both of which concur that the responsibilities in question should be assumed by the mental health services. The protagonists of the first view point to the fact that many observation wards in the provinces (London here presents a favourable contrast) are not equipped for the treatment of patients, are not staffed by medical personnel with experience of psychiatry and sometimes do not even have trained mental nurses. They hold that the functions of the observation wards should, in due course, be taken over by the combined action of Mental Hospitals and Psychiatric Units. The duties at present discharged by Relieving Officers towards psychiatric cases would fall upon the Medical Officer of Mental Health and his assistants. The Relieving Officer cannot, in the present state of the law, send a patient to a Mental Hospital on a three-day order. The observation ward is the only possible destination. A change in the law and a change in the attitude of the public towards the Mental Hospital—changes which would be facilitated if no one were formally certified till six months after admission—would make it possible for decisions as to disposal (which cannot now be made till after the patient's admission to the observation ward) to be taken at an earlier stage. A psychiatrically trained assistant of the Medical Officer of Mental Health could decide on first seeing the patient whether he

was suitable for immediate admission to a Mental Hospital and, with a change in the law relating to the three-day order, could send him in forthwith. A type of psychiatric case, on the other hand, for whom admission to a Mental Hospital was not deemed appropriate might be admitted to the nearest Psychiatric Unit. The observation ward might then disappear.

According to the second view mentioned above, facilities should be retained for treating 'observation ward cases' without sending them to Mental Hospitals. According to this view, a certain stigma is always likely to attach to a patient through the mere fact of having been admitted, for however short a time and on whatever kind of order, to a Mental Hospital. The protagonists of this view stress the fact that many cases admitted to an observation ward stay there but a short time before they are discharged as recovered. They also point to the improved prognosis of some acute psychiatric illnesses brought about by the use of convulsant therapy, and to the value of the observation ward as a sorting centre whereby subsequent transferences of patients from one hospital to another are avoided. It is urged that the type of patient admitted to an observation ward who to-day either gets well quickly of his own accord or else could be quickly cured by convulsant therapy, should not be sent to a Mental Hospital on any kind of order, or under any section of an amended Act.

To these arguments, the exponent of the point of view first put forward replies that in effect the arrangement proposed will defeat the intention of the Mental Treatment Act, and convert the Mental Hospital into a repository for chronic and hopeless cases, a place on entering which the patient abandons hope.

The proposals submitted in this report have, as one of their objects, the integration of institutional psychiatry with general medicine. Most people who take a long view will incline to the first rather than to the second alternative. At the same time, it is manifestly impossible to force public opinion in a matter of this kind, and the only possible course is to leave the solution in the hands of those cognizant of the local conditions and sentiments. Much will depend on the fate of the Poor Law and on the development of a more enlightened attitude towards the Mental Hospital.

In the event of the decision being taken to retain, for a time at least, the observation ward, new duties will fall to the mental health services. The staff of the Psychiatric Unit might be made responsible for a *Psychiatric Reception Ward* which might or might not (depending on local factors) form part of the Psychiatric Unit. The buildings and wards now used for purposes of observation might be adapted; staffs would need to be larger and better trained and ready to do 'ambulance' work, visiting the acute psychotic at his home and deciding about disposal; facilities for active treatment would need to be installed. Or new wards might be built near the Psychiatric Unit, so that the Reception Ward was in everything but physical structure a part of the unit. The majority of persons with whom I have discussed the matter were opposed to the idea of acute cases (describable by the public as 'mental') being admitted as residents to the *same building*

as that which contained wards for neurotic patients. While an exception was readily granted in favour of the Teaching Psychiatric Unit, it was thought that the objects for which the non-teaching unit was primarily established would be defeated by such a course; patients would be frightened of being admitted to the unit.

It is therefore suggested that beds in Psychiatric Units outside Mental Hospitals be provided at the rate of about 100 per million of population for patients who are not acutely ill and for whom the question of certification does not arise. The number and size of these units should be decided by the appropriate authorities after a careful survey of needs and facilities.

Over and above these beds, appropriate provision should be made by Mental Health Committees, again in the light of local facilities and needs, for the type of patient who is to-day admitted under a three-day order into an observation ward.

2. Psychiatric Out-Patient Clinics.

This matter can be considered both in terms of numbers of clinics per unit of population and in terms of their actitity—*i.e.* the number of sessions held per week and the number of doctor-hours.

The neurosis survey has shown that, in a population of 39,578,000 persons in England and Wales, there were 216 psychiatric clinics. These figures give an average of 5·47 clinics per million of population and an average unit of population per clinic of 183,000.

Of 169 Directors of clinics who expressed views on the subject, 71 (42·1 per cent) thought that new facilities should be opened in new areas (Table XXXV, p. 174). But these Directors were viewing the problem from the restricted standpoint of their own clinics. The eleven teams of regional investigators, who were able to survey their regions as a whole, were fairly unanimous in thinking that the existing distribution of clinics was inadequate, and several made specific recommendations as to where new clinics should be set up.

NUMBERS OF CLINICS AND DOCTOR-SESSIONS.

The survey has shown that, in the small centres of population, psychiatric clinics are usually staffed by doctors and accessory services whose headquarters are elsewhere. These clinics are visited once or twice a week (or less often) by a psychiatrist and perhaps a psychiatric social worker whose main sphere of activity is in another place—nearly always a Mental Hospital. The visiting staff constitutes a peripatetic team of varying size. This arrangement was discussed on page 20, where distinctions were made between *Central*, the *Affiliated* and the *Independent* clinics.

These distinctions, while not always easy to apply to clinics now in existence, may prove of value in devising out-patient services in the future.

In what follows, I shall mean by a *Central* clinic one which is the headquarters of a psychiatric team which visits other clinics; by an

Affiliated clinic one which is so visited by a staff with headquarters elsewhere; and by an *Independent* clinic one which is self-sufficient, having its own psychiatric staff which is not concerned with outside clinics. It was pointed out that several of the biggest Voluntary Hospitals have *independent* clinics in this sense. They have their own staffs (not relying on Mental or other Hospitals) which do not visit outside clinics. Such hospital departments are self-sufficient; but in the health services of the future they will probably undertake, more than heretofore, area responsibilities. Some may become Central clinics in the sense above defined.

The ratio of psychiatric clinics to population which existed during the years covered by the survey is shown in Table II, page 134. This ratio varies between different regions, being more than twice as high for regions in the south of England as for those in the north (7·75 clinics per million for Regions VI, VII and XII, contrasted with 3·7 clinics per million for Regions I and X). How far should the number of these clinics be increased?

This is a difficult question to answer because of wide regional disparities in density of population, in transport facilities and in what might be called 'psychiatric awareness'. So great are these disparities that it would be useless to propose a formula applicable to the country as a whole.

Let us compare, as representing opposite extremes, the conditions of London and Wales. London has a very dense population covering a small area. The communications are so good that it is possible for any patient, wherever he lives, to attend almost any clinic, wherever situated. The question that here arises is not so much the *number* of clinics as their location, activity and efficiency. Thus, a dozen well-placed clinics, generously staffed with doctors and accessory services and holding numerous weekly (including evening) sessions, might provide a better service than four times that number of small clinics, badly placed in relation to transport facilities, with meagre staffs of doctors and accessory services and holding few sessions. The *number* of clinics is here of subordinate importance to location, staffing and doctor-sessions. Then, again, in London there exists a high degree of psychiatric awareness. The doctors and the population are alive to the nature of psychiatric problems and to the services provided by the numerous large hospitals and well-run institutes. Despite the fact that psychiatric doctor-sessions per million of population are numerous compared with other regions, there is much pressure on clinics and much demand for expansion of services.

In Wales, on the other hand, the population outside Glamorgan and Monmouthshire is widely and thinly scattered, and transport facilities are poor. Distances are so large and communications so difficult that *numbers* of clinics become important. There were at the time of the survey no clinics in the three inland counties of Brecknock, Radnor and Montgomery; and though the Mental Hospitals of Wales have shown much enterprise in establishing affiliated clinics, the numbers of patients attending them are scanty. Of the 16 clinics in Wales, 10 held sessions monthly or less often, and 12 (75 per cent)

received on average less than 2 new patients per session. These small attendances are partly attributable to the fact that medical practitioners and population are 'psychiatrically backward'. Here is a remark made by the Director of one of these clinics:

'Hitherto this clinic has only functioned in skeleton form. The cases referred have been few, and adequate use has not been made of the clinic by medical practitioners and other potential referrers. Suitable propaganda is obviously indicated, and would, I believe, remedy the position. Improvement in the service offered would also help, and it is in my opinion essential that, as soon as circumstances allow, clinics should be held at weekly intervals.'

If we turn from a consideration of the *number* of clinics to that of *doctor-sessions*, we see the same difficulties in another light. Table IX (p. 140) gives the number of weekly doctor-sessions per million of population in the eleven civil defence regions. They will be seen to vary between 26·68 for Region V (an underestimate of the realities) and 4·94 for Region VIII. Yet pressure of patients exists in regions with numerous doctor-sessions no less, and sometimes more, than in those with few. Thus (Table XIII, p. 144) of 39 clinics in the London Region holding over 26 weekly doctor-sessions per million of population, 17 experienced pressure; whereas in Wales, of 16 clinics holding under 5 weekly doctor-sessions, none experienced pressure. These disparities are largely the product of differences in transport facilities and of 'psychiatric awareness' in the two regions.

These contrasts will illustrate the difficulties of compressing into a formula, applicable to a model area of a million population, an appropriate number of psychiatric clinics and of doctor-sessions. The optimum number of clinics per area must vary with the area's size and transport facilities. If there existed in all areas of the country, urban and rural alike, a similar degree of 'psychiatric awareness' and a similar volume of psychiatric abnormality, and if clinics were so distributed as to equalize everywhere the problems of transport, then we might be in a position to devise a universal formula for doctor-sessions. But as yet we are very far from this goal. As things stand at present, conditions vary so much in different areas that the solution must be left for each authority to find. It would be a mistake to embark on an ambitious programme of increasing the number of clinics and of doctor-sessions in a district which was 'psychiatrically backward' and unconscious of these needs. Nothing would be more futile than to arrange new sessions at a clinic to which there appeared no patients and whereat the staff sat about in idleness. The expansion of an area's services must keep pace with the development of that area's conscious psychiatric needs. In a psychiatrically backward district, it is necessary to educate both doctors and population. This can be done by arranging that lectures be given by the medical and accessory staffs of clinics to appropriate groups of lay people; medical practitioners can be made aware of available psychiatric services both by discussion at meetings of medical societies and by providing them with a service which experience teaches them is helpful (see p. 14). The

psychiatric services of every area should be so organized that they can easily expand as the need arises.

EXPANSION OF PSYCHIATRIC SERVICES.

How should these services expand ? The indications for expansion should be recognized in due time, before pressure is allowed to get unduly severe.

What is the appropriate number of patients for a single doctor-session ? The answer to this question depends on the length of the session. The desirable length is from two and a half to three hours. At the end of this period the psychiatrist (the psychologist and psychiatric social worker likewise) grows tired. The edge comes off his perceptiveness ; he loses some of his acumen and thoroughness : his interest flags, and the appropriate decision comes with increasing effort. How many patients can a psychiatrist see in a three-hour session ? The answer to this question depends on whether the social and domestic history has previously been taken by a psychiatric social worker. If these preliminaries have been completed before the patient reaches the psychiatrist, the latter is spared much time and effort, and he can usually do all that is necessary in half an hour. Six new patients then provide a maximum session's work : or, if old patients are also seen, four new and four old patients. The proportion of new to old patients can be varied on the basis that a minimum of half an hour is given to new cases and from ten to fifteen minutes to old. (If systematic psychotherapy is practised, old cases will need longer time.) If the help of a psychiatric social worker or student or other assistant is not available, *a new patient cannot be properly dealt with under an hour*. Good psychiatric work cannot be done in an atmosphere of hurry, when visions of long queues of waiting patients are disclosed every time the door opens. The psychiatrist's first interview with the patient is the most important, for it is then that initial ' rapport ' is established and the necessary confidence generated. The psychiatrist should have time to make all necessary inquiries of relatives, to ask all appropriate questions of the patient, to conduct a careful physical examination (which itself has an important psychotherapeutic value) and to reach a well-grounded decision as to what is to be done. This essential decision should be taken at the first interview ; for, if not then reached, it gets postponed and becomes increasingly difficult to formulate. Time should be allowed in the session to dictate an appropriate letter to the referring doctor. Much depends on this letter, for which clerical assistance should be available. The psychiatrist may like to dictate the draft of a letter after he has finished with each case when it is fresh in his memory, or he may prefer to dictate all the necessary letters at the end of the session. As previously remarked (pp. 14–15), the attitude of the outside practitioner to the clinic will depend much on the helpfulness of the letters he receives from its medical staff.

An appointment system should always be followed. The lengthening of the waiting list based on such an appointment system is a sign that expansion is needed. This expansion can be achieved either by

increasing the staff of the clinic at each session, or by arranging for more frequent sessions, or by establishing a new clinic in another area. The psychiatric social worker sometimes finds it a good plan to keep on her wall a large-scale map of the area served by the clinic, marking thereon the homes of its patients. Such a map shows the clinic's geographical range, and may provide a good indication of when an affiliated clinic should be started in a neighbouring centre. These extensions of range often reflect the fact that practitioners in certain areas are making increasing use of the clinic's services.

I now return to the question of how far the existing provision of psychiatric out-patient clinics should be increased. It would be difficult to devise a formula in terms of numbers of clinics or of doctor-sessions which would be applicable equally to all the eleven civil defence regions covered in the survey; and it would be still more difficult to offer one for the thirty or thirty-five areas which have yet to be defined. The most that can be done at this stage is to recommend that the out-patient services (number of clinics, their staffing arrangements and their sessions) be planned so as to make anticipatory provision for expansion. The survey has drawn attention to psychiatric backwardness in some regions or parts of regions, and to pressure on existing psychiatric facilities in others. The nearest approach to a general formula permissible from the results of the survey would, in my opinion, be that authorities should lay their plans in expectation of a 75 to 100 per cent expansion in facilities in the course of the next five years.[1] Such an increase would be attained by establishing new clinics, by augmenting the staffs and accessory services of existing clinics, or by increasing the number of weekly sessions of these clinics in accordance with the particular and varying needs of the area. It would be desirable if, in a co-ordinated area scheme, the staffs of active 'independent' clinics of big Voluntary Hospitals would undertake area responsibilities and establish 'affiliated' clinics in suitable centres; if, to use the terminology above proposed, they became 'central' clinics.

CHILD GUIDANCE SERVICES.

In Chapter IX (p. 53) a distinction was drawn between the Child Guidance Centre and the Child Psychiatric Clinic. On what scale, in a population of a million, should these be provided?

3. Child Guidance Centres.

It was above suggested that Child Guidance Centres should be established under the jurisdiction of Local Education Authorities and that they be regarded as the headquarters of a psychologist. This officer's duties would, broadly speaking, be to carry out for the Authority any work for which the training of an educational psychologist was found to be useful. Her work would include survey work in the schools, assisting teachers to carry out and interpret the results

[1] See pp. 147–149 for an estimate of the attendances which would result if the experiences of London were shared by the whole country.

of mental and scholastic tests, advising generally on the psychological aspects of education, especially for subnormal and other handicapped children and for exceptionally able children; she would also advise on problems raised in the schools by individual children who presented difficulties to their teachers either in their response to education or in their behaviour. Here the collaboration of a psychiatrist and a psychiatric social worker would be essential. The psychiatrist could give treatment to children either in the Child Guidance Centre or in a Child Psychiatric Clinic: the choice would depend on local factors, among which transport facilities would be important. A hostel for children, attached to the Psychiatric Clinic (see p. 76) would make it easier for Child Guidance Centres far afield to use the clinic.

A population of a million would contain about 200,000 children between the ages of three and sixteen. It has been estimated that, in an average school population, between 1 and 2 per cent of all children need child guidance each year. But this estimate should not be taken too rigidly, for the figure varies in different localities, as does the incidence of delinquency. The proportion of children, moreover, who are deemed to need guidance depends on the standards which are adopted. A small variation upwards or downwards in standards, such as might occur from one locality to another, might substantially alter the numbers of children held to need guidance.

A population of 20,000 school children is the maximum which can be efficiently handled by a single psychologist. If from 1 to 2 per cent of school children need guidance annually, 20,000 children would yield from 200 to 400 children needing attention. *Ten centres, each covering a population of* 20,000 *children*, would be required in an area of a million persons of whom 200,000 were children. In compact and densely populated districts, the psychologist would be closely based on her centre.

The number of sessions per week and the places in which they were held would be determined by local circumstances, of which an important feature would be the size of the district and the distribution of schools therein. In scattered areas the psychologist's work would involve much travel and visiting of schools. Her apparatus is portable, the presence of the teacher is a big help, and the home surroundings as well as the attitude of parents are best appreciated on the spot. The position of Mid-Wales would be very different from that of a large industrial town. In the former, much of the work would be peripatetic, and it would be impossible to meet the area's needs by sessions at fixed times in a single place. Nevertheless, the psychologist would need to have a headquarters, and this we might regard as her centre.

The Child Guidance Centre, forming part of the area's education services, should be linked to the health services by the psychiatrist who attended regular sessions.

4. Child Psychiatric Clinics.

In previous paragraphs of this chapter were put forward suggestions that, in each area of a million there should be provided about 100

psychiatric beds outside Mental Hospitals in Psychiatric Units; also an appropriate number of Central Psychiatric Clinics to do the area's out-patient work. The larger and more active of these central clinics would be placed in the area's main centres of population where they would form part of Psychiatric Units—*i.e.* have behind them beds wherein suitable cases could be admitted and, if necessary, seen by a paediatrician.

A further distinction was made between two kinds of central clinic, the first providing facilities for child psychiatry and incorporating a *Child Psychiatric Clinic*, the second restricting its activities to adults.

In the questionnaire used in the neurosis survey it was asked whether each psychiatric clinic dealt with children and, if yes, whether they were received at the same sessions as adults or at separate sessions. The results are set out in Table XII (p. 143). The majority of clinics received children. Of 187 clinics which answered the question, 165 (88·2 per cent) replied that children were seen and treated; in 145 of these 165 clinics, children were received at the same sessions as adults, and in 20 at separate sessions. The majority of clinics which received children did not therefore make special arrangements for them.

If in the future child psychiatry is to become an essential feature of the mental health services, the Child Psychiatric Clinic, with its special team and specialized function, should form an essential part of the services provided by the Central Psychiatric Clinic.

The psychiatric team in question consists of a psychiatrist, a psychologist and a psychiatric social worker. Sessions for children should be held at separate times from those for adults, and the department of the Central Psychiatric Clinic which deals with children should have quarters of its own. Of these, a spacious room for play, giving into a garden or open-air porch, is desirable. Since most existing hospitals may not have adequate premises for both adult and child psychiatry, some Joint Authorities may want to build especially for this purpose. Plans for a complete Central Psychiatric Clinic with suitable accommodation for a children's department are available at the Ministry of Health for interested persons.

Staffing arrangements for the adults' and children's parts of the clinic will doubtless vary with local conditions and personnel. While every psychiatrist should have experience of both sides, it will probably be found convenient to have in charge of the Child Psychiatric Clinic a psychiatrist who specializes in children. He will make more use of the psychologist than his colleague who deals with adults, and he will need at least one full-time psychiatric social worker. A fixed amount of his time should be given to peripatetic work, and he should attend regular weekly sessions at one or more of the area's Child Guidance Centres. At these he would see children who presented psychiatric problems, some of which he could arrange to treat at the fully equipped Child Psychiatric Clinic. Here the opinion of a paediatrician would be readily available; there would be ample facilities for play therapy; and (much child psychiatry depending on the appropriate handling of the parents) adults could, if necessary, be treated.

How many Child Psychiatric Clinics should be contained in an area of a million ? An important consideration here is that the number and location of these clinics should have some relation to those of Child Guidance Centres. The psychiatrist in charge of the ' Clinic ', or an assistant, would attend regular sessions at the ' Centres ', and would be available for help and advice to the medical services under the Education Authority. He would also see at the ' Clinic ' children referred through other channels than the ' Centres '. A balance must be found between the time spent inside and outside the ' Clinic '. A proportion of one Child Psychiatric Clinic to three Child Guidance Centres would seem appropriate. In an area with ten Child Guidance Centres, three or four Child Psychiatric Clinics would then be needed.

PRESENT AND FUTURE CHILD GUIDANCE SERVICES.

The proposals for the future submitted in the last two paragraphs envisage an enormous expansion of the existing child guidance services. There are at the time of writing about ninety-five Child Guidance Clinics in the country. Though these may incline differently towards a medical or an educational outlook, there does not at present exist a differentiation as clear as is implied in the separation above proposed of the Child Guidance Centre from the Child Psychiatric Clinic. A provision of ten Child Guidance Centres and three or four Child Psychiatric Clinics per million of population would involve, for the country as a whole, the establishing of some 400 Child Guidance Centres and some 150 Child Psychiatric Clinics. It would mean multiplying the existing clinics by about six. Such a programme calls for an enormous development of existing training facilities for child psychiatrists and for accessory services—a process that might take two four-year plans to realize. I would not dare to make a proposal of such magnitude if I did not feel that the main orientation of the mental health services of the future should be towards prevention rather than cure, and hence towards the needs of the child. The nation's children are its most precious asset ; no funds spent in their interests and no trouble taken on their behalf are misdirected.

5. Hostels for Difficult and Unstable Children.

Since the outbreak of the war there have been established by the Ministry of Health some 225 hostels throughout the country for difficult children. These hostels were primarily designed for evacuated children who gave trouble to the people on whom they were billeted or who were known to be unsuitable for billeting ; but they fulfilled indigenous as well as emergency needs, and, to a small but increasing extent, have been used for the reception of local as well as of immigrant children. In July 1943 there were just over 3400 children in these 225 hostels, whereat psychiatric services were in varying degrees available.

The value of these hostels has impressed all observers, and the demand is general that in some form they be perpetuated after the war.

On what scale should they be provided? Various considerations have to be taken into account, such as the size of the area, the availability of psychiatric guidance and advice, and the children's educational requirements.

The above-mentioned figure of 3400 'hostelized' children for the country as a whole gives about eighty-five such children per million of child and adult population. It might be argued that this figure was too large to take as a basis because many of the children would, after the war, return to their homes where they would be more manageable than in the homes of emergency foster-parents.

I suggest that, as a start, each area of a million provide residential hostels for about fifty normally intelligent but unstable children. A likely age distribution for these would be the following:

Group.	Numbers.
Boys aged 6–11 Girls „ 6–14	30
Boys „ 12–16	15
Girls „ 14–16	5
Total	50

The Child Guidance Committee of the Provisional National Council for Mental Health recommend that hostels be small. Close personal relations with adults are facilitated if the inmates do not exceed eight to ten; if the hostel be larger, the children should be divided into groups of about this size, each under an adult. Education should be provided in a neighbouring school; this gives a stimulus absent in a residential school. The hostel would come under the jurisdiction of the Education or the Health Committee, or could be administered jointly; and adjustment would be needed if the areas covered by the two were not coterminous. The hostel should be in close geographical and functional relation to a Child Psychiatric Clinic, preferably that which forms part of a Teaching Psychiatric Unit. The hostel would be useful for accommodating children sent for treatment from Child Guidance Centres far afield. Medical students and such accessory services as might be trained in the teaching unit would benefit from seeing what can be done by skilled handling outside the home for a group of difficult and unstable children. It is the child of average or above-average intelligence who reacts best to the atmosphere of such a hostel. The hostel's influence for good would suffer if it came to contain a majority of dull and backward children; these are better cared for in other places.

6. Children's Reception Centres.

For many possible reasons it may suddenly be necessary to find a new home for a child. One or both parents may fall ill, be sent to prison, become insane, or die; the home may break up because of parental discords; the child may behave in such a way that removal

from the home is deemed advisable or perhaps ordered. To-day the disposal of such children is haphazard. They may be sent to a Public Assistance Institution, to a school administered by a charity organization, to a school under Section 30 of the Education Act. Occasions arise when a child can be sent to one of several residential destinations, and its fate depends much on chance factors.

It would be helpful to the responsible people concerned if facilities were established for examining these children at leisure, for investigating their home background and for assessing each individual case on its merits. The course followed may affect the child for the rest of its life; hence the decision should not be hastily taken. There should be no pressing hurry and no sacrifice of the child's long-term interests to consideration of immediate convenience.

The dimensions of the problem can be gauged from the fact that there are at present some 86,000 children in schools or institutions for the destitute and homeless. Some of these establishments are well administered by enlightened people; others leave much to be desired, and it would be a good thing if attention were called to the conditions which prevail in them.

It is here proposed that, in each area of a million, there should be established, again in close association with the Teaching Psychiatric Unit, a *children's reception centre* to which could be sent, through the channels of any responsible agency, children who, for any reason whatsoever, have to be found a home. The child's admission might be an emergency measure pending its placement with some relative; or it might be a preliminary to some arrangement whereby the community takes responsibility. The child would remain in the reception centre until the necessary information had been obtained about its home and social background, and until such investigations of personality and mental resources had been completed as would lead to the best disposal. Magistrates might find the centre a convenient place for remanding juvenile delinquents for further investigation and report. It is the general experience that many delinquent children, when thus sent away from home for investigation, behave well and are with difficulty distinguished from other children.

The average length of time spent by a child in the reception centre would be about a fortnight, though it might range from a single night to a month or longer. The majority of children received would be mentally normal; a substantial minority, however, might show psychiatric ab- or subnormalities needing expert assessment. If, as suggested above, the reception centre were placed near the Teaching Psychiatric Unit, full advantage might be taken of the services of the unit's Child Psychiatric Clinic. By the staff of this clinic as well as by medical and other students, valuable advantages would be derived from being brought into contact with *normal as well as abnormal children*. In several medical specialties, stress is now being laid on how the student should learn to recognize the bounds of the normal before attempting to evaluate the abnormal. This principle holds with much force in child psychiatry. But here is the added difficulty that the bounds of the normal—of normal intelligence and normal

behaviour—change with age. The work of a Child Reception Centre, furthermore, would provide a valuable training in social medicine and an insight into its sad and sordid aspects. The proposed association with the Psychiatric Unit would link up the psychiatric services of an area with the various institutions, schools and homes wherein children might be placed. Some sort of specialization might be introduced into these places to meet the needs of the area. Local cognizance would be taken of how they were administered, and reforms introduced where they were needed. Much healthy light and air would be let into some quarters.

How should a Child Reception Centre be organized? Since the period of residence would be short—perhaps an average of a fortnight—there would be no general need for teaching nor for any established relations with a school. But since many of the centre's inmates would, prior to admission, be attending schools, the Education Committee would be much concerned in its activities, though it is doubtful if it could be the responsible authority. The following age-distribution is suggested:

Age-groups.	Numbers.
0–4 Nursery: both sexes	8
5–11 Juniors: both sexes	15+15
12–16 Boys	15
12–16 Girls	15
Total	68

Within the reception centre some differentiation or grading of children might be found desirable. The Royal Medico-Psychological Association has urged that, before certification, every high-grade defective should be kept for a time under observation in a special unit or in an existing institution. A part of the reception centre might be adapted for this purpose. A similar argument applies to certain delinquents whose inclusion, for purposes of observation, in the reception centre would serve a different purpose from that of the 'Classification Schools' which are being set up by the Home Office. The latter play their part at a later stage in the delinquent's career, and are designed to effect best placement, after an order has been made by the Court, in the differently specialized Remand Homes and Schools.

The proximity of such a centre to a Teaching Psychiatric Unit would again provide valuable material in a new field. All agree that psychiatrists could help in the problem of delinquency both by giving expert advice to the courts and, in suitable cases, by providing treatment. The arrangement here suggested might do much to stimulate and develop this important branch of psychiatry.

The accommodation for Child Reception Centres might largely consist, as a start, of converted Army huts. The children, whose period of residence would be short, could be housed in units of up to twelve or fifteen. The permanent staff would need more substantial accommodation.

The success achieved by the organizations described in this and

the preceding paragraph—the hostel for difficult and unstable children, and the Children's Reception Centre—would largely depend on the staffs of these places. These would have to be fairly numerous and very well trained. Miss Leila Rendel, a Director of the Caldecott Community now established at Wareham, Hants, has adapted her community to the threefold functions of an area reception centre for investigating and sorting homeless children, of a home or hostel for difficult and unstable children, and of a training centre for workers in this field. Miss Rendel's is a pioneer experiment, from which much may be learned.

7. Accommodation in Mental Hospitals.

A review of the mental health services of an area of a million would not be complete without a reference to the accommodation in Mental Hospitals and Certified Institutions, though the subject is outside the scope of the neurosis survey.

The report for 1938 of the Board of Control states that on 1st January 1939 there were in England and Wales 158,723 persons suffering from mental disorder (of whom 133,596 were in County and Borough Mental Hospitals), thus giving an average of about 3900 per million of population. Since that year the war has caused changes. The Emergency Medical Services have taken over some of the best accommodation in Mental Hospitals; staffs have been much depleted by the demands of the Forces; and doctors remaining at their posts have worked against great pressure. The admission rate fell in the three years 1940–42, but is now rising and may return to its pre-war level. The existing provision will probably be just sufficient to meet the needs of the immediate future; but in five or ten years there may again be pressure as the proportion of old people in the country rises. Relief—of perhaps 5 per cent of present numbers—would follow if better provision were made for mental defectives, many of whom are at present unsuitably detained in Mental Hospitals. Much, indeed, can be said for giving some priority to the needs of mental defectives, not only in their own interests but also in those of the inmates and staffs of Mental Hospitals.

Mental Hospitals vary much in the numbers of their patients, the range being from 400 to over 3000. As has been often stressed by the Board of Control, it is from every point of view undesirable that the inmates of any Mental Hospital should exceed 1000.

With 3000 patients the place becomes unwieldy; the medical staff (unless very large) is swamped by the crowds of cases; clinical work is displaced by administrative; and the Medical Superintendent has little hope of knowing all the patients. The difficulties have been mentioned of doing justice to new out-patients under conditions of pressure. Similar considerations apply with equal or greater force to work inside Mental Hospitals. If he is to do good work, the psychiatrist must have time to think; there is nothing so discouraging for a keen man with active clinical interests as to be so deluged and snowed under with patients that his dealings with them become perfunctory and his

main preoccupation becomes that of satisfying official requirements. Originality is stifled, the impulse to research is extinguished and work is reduced to a low level of mediocrity.

Comment has been made above on the need of educating the public to the true nature of mental disorder, thus abolishing outworn prejudices about lunacy and lunatic asylums. Many of these beliefs owe their tenacity to the dismal conditions which prevailed in the lunatic asylums of the past; and it will be difficult to exorcise them completely as long as disparities continue to exist between the conditions prevailing in General and Mental Hospitals. It will be a waste of time for voluntary organizations concerned with mental health or hygiene to try to enlighten the public about the true nature of mental disease if the conditions obtaining in many Mental Hospitals fall below the standards which are recognized for General Hospitals. The provision of adequate staffs for Mental Hospitals and the reduction of their inmates to reasonable proportions are necessary steps towards raising the standard of institutional psychiatry, towards attracting into the specialty good men with active clinical interests and towards mitigating the fear in which the Mental Hospital is still sometimes held.

These measures have yet another implication which bears on the proposals of this report. In previous chapters, various extensions of in- and out-patient services outside Mental Hospitals and of children's services have been advocated; and it has been argued that the bulk of the new work should be undertaken by psychiatrists in the Mental Hospital Service, some of them working on a part-time basis. It will clearly be difficult for these men to apply to this outside work high standards of keenness and thoroughness if the work in their parent hospitals is perforce graded to a lower standard. Human effort is apt to follow the line of least resistance, and the standards prevailing at the centre will tend to be applied at the periphery. If the mental health services are to be unified, the conditions of a psychiatrist's work in his Mental Hospital will have effects which radiate far outside the confines of that place. The heart must be sound if the limbs are to be vigorous and healthy.

The lines on which a Mental Hospital should be planned have been clearly described by the Board of Control. The needs of an area of a million would be satisfactorily met by three or four Mental Hospitals of about a thousand beds each. In the last ten years increasing proportions of Voluntary Patients have been admitted to Mental Hospitals, and it is right that these should claim a full share of the staff's time and energies. The hospital should be so staffed that everything possible is done for these. It is the work in the admission and convalescent block which yields best dividends; its results can be measured in terms of benefit to the patient, of satisfaction to the staff, of the morale of the hospital as a whole, and of financial economy for the community. In every Mental Hospital is to be found a fairly stable proportion of chronic patients whose prospects of recovery are small. For these little can be done, especially as they grow old, to restore them to active life in the community and to full mental health. Such patients should be made as happy as possible. They should be well fed, comfortably

housed, properly classified and segregated, appropriately occupied, cheerfully and kindly handled, and at intervals suitably entertained. Little more can be done for them.

Some time may elapse before beds in Mental Hospitals are universally provided on the scale above suggested. In the meanwhile, needs could be met, when the Poor Law breaks up, by using buildings now provided by Local Authorities for chronic and senile patients. The buildings so transferred could be administered as ancillary premises of Mental Hospitals.

A Mental Hospital of 1000 beds, making full use of modern therapeutic methods including convulsant therapy, and having an annual turnover of 30 or 40 per cent of its patients, should have, for intra-mural work only, a staff which includes a Medical Superintendent, five or six full-time medical officers (or more if some of the intra-mural work is part-time) and at least one psychiatric social worker. Or we might say that there should be one doctor for every 150 resident patients and one psychiatric social worker for every 150 admissions and 80 discharges per annum. If extra-mural duties are undertaken—as they should be—the staff should be larger. The Royal Medico-Psychological Association holds that both medical and nursing staffs should be materially increased, in some cases by 100 per cent over the low pre-war standards. Every member of the permanent medical staff should take some part in the outside activities, in which the nursing staff should also participate. It is suggested on page 56 that part-time work in the service should be encouraged, the duties lying both inside and outside the hospital. Individual members of the staff might be encouraged to specialize in different extra-mural activities. The sum total of work would be varied and stimulating; it would hold attractions for a wide circle of potential recruits; and it would offer good prospects to men with clinical interests. Indeed, we should think of a Mental *Health* rather than of a Mental *Hospital* Service.

8. Accommodation for Mental Defectives.

The Wood Committee (1929) estimated that there existed in England and Wales some 300,000 mental defectives; this figure gives 7500 cases per million of population. How many of these need institutional care?

The Wood Committee's answer—and it is the best answer available—was 3·20 per thousand for rural and 2·17 per thousand for urban districts. The assumption that 20 per cent of this country's population of 40 million are rural and 80 per cent urban confronts us with a total figure of just under 100,000 defectives needing residential care.

On 1st January 1939 some 46,000 mental defectives were residing in colonies, institutions, houses and homes under the Mental Deficiency Act. This figure gives an average of just over 1000 beds per million of population. The Board of Control regards this provision as seriously inadequate, and follows the Wood Committee in holding that the country's total provision should be raised to 100,000 beds, which would give an average per million of population of 2500 beds.

There is thus needed two and a half times the institutional provision for mental defectives that is now available.

The Colony, whose optimum size from the standpoints of administrative convenience and of the welfare of its inmates is from 1000 to 1200 beds, provides the best form of accommodation. If built on the villa system, it allows of better classification and training of defectives, and secures for them happier and more contented lives than does the institution of the barrack type. Mental defect is legally classified into three grades, according to which education (when this is possible), training and recreation should be varied. A Colony of between 1000 and 1200 inmates admits of the necessary classification and segregation, thereby lightening the arduous duties of teachers and nurses, and producing results which parents are able to recognize when they visit their children. Such a Colony should contain a residential school and should be divided into villas containing not more than 60 patients. According to the recommendations of the Hedley Report, it would contain 23 villas.

As a result of the existing shortage of suitable space, many defectives are to-day retained in Mental Hospitals and Poor Law premises approved under Section 37 of the Mental Deficiency Act. The number placed in Mental Hospitals is difficult to gauge, but it has been estimated that, if other accommodation could be found, pressure on Mental Hospital beds could be relieved by about 5 per cent.

Needs would be met if, in each area of a million, two Colonies were provided for from 1000 to 1200 inmates. Or the Colonies might be smaller—containing some 800 beds—and have affiliated hostels for some 300 to 400 cases.

At first sight the difficulties and costs of such an enterprise will appear staggering: indeed, their dimensions are such as to obscure the very tangible gains which would result from a vigorous handling of this problem. The majority of defectives are trainable and, with proper training, can be turned into socially useful human beings. Many can be taught to do simple repetitive manual work both in agriculture and industry. The task, once mastered, is performed with a thoroughness and fidelity which are a surprise to many. The Colony is the best place for a certain type of defective to be thus trained, and arrangements can then be made for small groups of patients to be boarded out in special hostels, under the supervision of the parent Colony, from which they can engage in remunerative work in field and factory. It is better both for the community and the defective that he should be thus stabilized and employed than that he should drift into unemployment or delinquency, becoming in indirect ways a burden on the community. The Wood Report contained valuable recommendations as to how the Colony should be used as a training centre through which would pass a stream of trainable defectives for whom would be found, on discharge, suitable niches in the community's working life. The Colony would also contain a permanently resident nucleus of ineducable low-grade cases, comparable to the Mental Hospital's chronic and senile psychotics mentioned in the preceding section; but the dynamic conception of the Colony

outlined and advocated by the Wood Committee is one which, when adopted, transforms the outlook of the staff. Work in residential institutions for defectives is sometimes regarded as the most dismal and uninspiring backwater in medical and social work. This view is quickly dispelled by a visit to an enterprising Colony which aims at training the maximum number of its inmates for specific tasks and at placing them suitably outside.

It was submitted in the preceding section that the efficiency with which extra-mural psychiatric duties would be discharged by psychiatrists based on Mental Hospitals would depend much on the conditions which prevailed in the Mental Hospital itself. Similar considerations apply to the relation between the Colony and community schemes for training, placing and supervising mental defectives. These have been much developed in the period between the wars, both by the Officers of Local Authorities who have worked out many good schemes, and also through the activities of voluntary organizations. The presence of one or two dynamic Colonies in an area would greatly stimulate and facilitate this outside work. At a time when the country is considering schemes of social security which depend for their success on restricting unemployment to prescribed limits, there is much to be said for making vigorous efforts to deal with those elements in the community which are most likely to fall into helpless dependency. The direct expenditure thereby entailed may effect larger indirect savings, measurable in terms not only of cash but of human well-being.

The Board of Control is of the opinion that a Colony of a thousand should contain a residential school, appropriately staffed; and the other personnel required for work inside the Colony should include a Medical Superintendent, four medical officers, a psychologist and a psychiatric social worker. But the medical and nursing staff of Colonies should engage actively in extra-mural work, both in the child guidance services and in schemes for community care. Additional staff would be needed for this work.

The *prevention* of mental defect is a complex problem with medical, obstetric, genetic and social aspects. Some of these are dealt with in Chapter XIV (pp. 102–108).

9. Community Care for the Mentally Subnormal.

What provision should be made in a population of a million for the community care of mentally subnormal persons? This is a difficult problem about which experienced people are loath to commit themselves. The best available guide is the Wood Report, which examines this question in minute numerical detail.[1]

As previously remarked, the Wood Committee estimated that there were some 300,000 mental defectives in England and Wales. The Committee's survey unavoidably missed some very young children and some adults, so that the estimate for the country as a whole, based on the findings in the six sample areas, was less than 300,000. The figure is given as 288,556 persons. These are divided by the

[1] See Part IV, Chapter V, of the Wood Report.

Wood Committee into a class which needs residential care and a class which needs community care. These two classes are subdivided as follows :

Cases needing institutional care :	
Adults	83,736 [1]
Low-grade children	17,297
Feeble-minded children	23,251
Total	124,284
Cases needing care in the community :	
Adults	61,722
of these, some 13,000 need guardianship and some 48,000 need supervision, strict for about 7000.	
Low-grade children	13,610
of whom most will need occupation centres where numbers might be increased by some feeble-minded children.	
Feeble-minded children	81,258
of which most need special day schools or other provision, including schools for special disabilities.	
Total	156,590
or, more closely	164,272 [2]

If we translate the figures for cases needing community care, which are expressed for the country as a whole, into terms of the provision required for a population of a million, we are confronted with large numbers. These give an indication of the magnitude of the task which here confronts Mental Health Committees. Here are the figures :

Adults	1540
of which some 320 need guardianship and some 1200 supervision, strict for about 170.	
Low-grade children	340
mostly needing occupation in centres.	
Feeble-minded children, about	2000
A large proportion of these, perhaps some two-thirds, would be absorbed in schools for special disabilities.	

According to the above estimate, a population of a million would need to provide community care for nearly 4000 persons, including over 1000 feeble-minded children who would be trained in schools for special disabilities. Voluntary organizations have, in the past, done valuable work in this field. Their activities should continue to be co-ordinated with those of Local Authorities if these extend their field.

[1] Of these, 76,262 need to be placed in Colonies.
[2] See Wood Report, Part IV, page 163.

CHAPTER XII

THE MEDICAL OFFICER OF MENTAL HEALTH

FOR the last fifteen years people have recognized that the increasing diversification of the mental health services has given rise to a need for their co-ordination under a single authority. As long ago as 1929 the Wood Committee (Part III, para. 88) stated that

'in each administrative area there should exist some central controlling and co-ordinating authority' who should be concerned not only with problems of the community care of mental defectives, 'but also the making of arrangements for the establishment and carrying on of out-patient clinics and for the giving of courses of instruction to social workers and other cognate duties.'

The same plea was put forward by the Feversham Committee in 1939 (para. 118); and in the many discussions on planning which have taken place in the last two years, the appointment of a Medical Officer of Mental Health has been supported by various organizations. Among these may be numbered the group on psychological medicine of the British Medical Association, the Royal Medico-Psychological Association, the Mental Hospitals Association and others. The mental health services of the future will form a complex organization, and the need for their co-ordination will be greater than in the past.

The Feversham Committee pointed out that in most areas there is at present little liaison between the committees of the Local Authority which deal, from different standpoints, with problems of mental health. These problems come up before the Visiting, the Mental Deficiency, the Education and the Public Assistance Committees. The Feversham Committee suggested that the Visiting and the Mental Deficiency Committees of the Local Authority be fused in a *Mental Health Committee*, and that joint sub-committees be established between this body, the Education and Public Assistance Committees. Of the Mental Health Committee, the Medical Officer of Mental Health would be the chief executive officer. This man would, in the words of Dame Ellen Pinsent, quoted in the Feversham Report:

'help to ensure that the same standards are taken throughout the district, and not, as we believe to be the case, that the Poor Law Medical Officers, the School Medical Officers and the general practitioner all vary in their estimate of what constitutes certifiable insanity, or which cases should be dealt with under the Mental Treatment Act and which should be certified under the Mental Deficiency Acts. At present we are inclined to think that these standards vary considerably and often to the detriment of the patient.'

In preceding chapters, the mental health services have been viewed from the standpoint of the Teaching Psychiatric Unit and of the Mental Hospital. It will now be convenient to consider them from the angle of the Medical Officer of Mental Health, if such an officer were appointed.

The following are among the activities which would enter the province of this officer. They fall under the same general headings as those enumerated in Chapters VII, X and XI :

1. *Out-Patient Services.* Minimum standards as to these may be recommended by some central authority. These standards might not be satisfied by the existing arrangements, which would accordingly require to be expanded or strengthened. Apart from initial changes, adjustments would later be needed if pressure, in the shape of lengthening waiting lists, developed at certain clinics. Sessions might need to be increased in number, more medical staff provided, or new clinics founded. The Child Guidance Centres and Psychiatric Clinics established for children would require co-ordination.

2. *Provision of Beds outside Mental Hospitals.* Non-Teaching Psychiatric Units will probably be set up in certain Voluntary Hospitals, and beds provided according to a certain scale. In the preceding section a scale of 100 beds per million population was suggested. Organization will be needed here.

3. *Psychiatric Emergencies.* These have mostly been dealt with hitherto by Relieving Officers ; but new arrangements are foreshadowed by changes in the Poor Law. The appropriate handling of psychiatric emergencies should form just as essential a part of a comprehensive medical service as that of physical emergencies. If the law relating to the three-day order were changed, and if psychiatric emergencies calling for immediate disposal were seen by a person with psychiatric training, the necessary sorting of cases could be done at an earlier stage than now. A psychiatric social worker, male or female, working under the Medical Officer of Mental Health would be the right person to deal with psychiatric emergencies.

4. *Ascertainment.* When the existence of a child thought to be mentally defective is disclosed, he is brought into the presence of the Certifying Officer for special examination. This officer is usually the School Medical Officer or some other officer on the Local Education Authority's staff, who must be approved under Section 55 of the Education Act, 1921, and under Section 31 of the Mental Deficiency Act, 1913. If the proposed Mental Health Committee of the Local Authority had appropriate liaison with the Education Committee, as has been suggested, the duties of ascertainment might be supervised by, or even assigned to, the Medical Officer of Mental Health. The existence of a service of psychologists under the Education Authority, with their headquarters in the Child Guidance Centres, would help much in the process of ascertainment.

5. *Community Care of Mental Defectives.* The provision of occupation and handicraft centres ; the placing of defectives in foster-homes —*i.e.* the selection of appropriate defectives and of suitable homes ; arrangements for guardianship, for statutory and for voluntary supervision would be among the responsibilities of the Medical Officer of Mental Health.

6. *Criminal Psychiatry and Delinquency.* The Feversham Report draws attention (paras. 401–404) to the unequal distribution of psychiatric services in Juvenile Courts. The London County Council

provides a psychiatrist who examines every child ; yet a limited inquiry as to the use made of psychiatrists and psychologists in criminal courts showed that, in seventy-five out of a hundred areas, nothing in this way was done. The provision of such a service would be a clear duty of the Medical Officer of Mental Health.

The same might be said of a psychiatric service for prisoners : if the Medical Officer of a prison thought that a prisoner would benefit from some form of psychotherapy, or if he wanted a second opinion on the mental state of a prisoner, he would turn to the Medical Officer of Mental Health. As previously observed (p. 60), a need for the services of psychiatrists arises from the Criminal Justice Bill, 1939.

7. *Industrial Psychiatry.* Industrial Medical Officers confronted with cases of psychiatric abnormality may themselves want an expert opinion. Or they may refer the patient back to his private door, recommending that the latter obtain such an opinion. Where should they send the patient ? Or where should they recommend to the patient's doctor that he be sent ? They would turn to the Medical Officer of Mental Health for guidance. Everyone now agrees that vocational guidance has close connections with mental health. It is not yet clear how far such a service will be directed by the Local Education Authorities or by representatives of the Ministry of Labour. If the Medical Officer of Mental Health were to be asked to concern himself with such work, he would probably have dealings with Employment Exchanges (see p. 59).

8. *Special Schools and Hostels.* The establishment and administration of special schools and perhaps of hostels for mentally infirm children is to be regulated by the Minister of Education ; [1] use might be made of the Medical Officer of Mental Health.

9. *Co-operation with Voluntary Organizations.* The adjustment of the activities of voluntary bodies to those of statutory committees will be one of the main duties of this officer.

10. *Education in Mental Health.* In Chapter XI (2), page 72, were discussed the difficulties of suggesting minimum standards for out-patient services. These difficulties arose from the varying degrees of ' psychiatric awareness ' which exist in different parts of the country. Some of the less urbanized districts are psychiatrically backward and would not fully utilize services which, in another district, would be regarded as inadequate. In backward districts, the expansion and development of psychiatric resources must keep pace with the willingness of doctors, magistrates, probation officers, parents and patients to use them. The education of the public in the elementary principles of child development and mental health, and their introduction to such psychiatric services as are developed, should fall within the province of the Medical Officer of Mental Health. This matter is further discussed on pp. 115–118.

11. *Surveys and Follow-Up.* In Chapter VII the promotion and co-ordination of research was mentioned as one of the main functions of the Teaching Psychiatric Unit. The Medical Officer of Mental Health should maintain close contact with the professor of psychiatry

[1] Education Act, 1944, Section 33.

in such a teaching unit, who would be interested in all psychiatric surveys and follow-up inquiries. From the administrative standpoint, such inquiries are necessary in order to gauge the value of the services on which public money is spent.

The eleven activities of the Medical Officer of Mental Health above-mentioned are suggested tentatively. They are not put forward as either exhaustive or complete ; but they permit of a general evaluation of this officer's important rôle in the mental health services of the future, which can now be considered from certain other standpoints.

Relations of Medical Officer of Mental Health. This officer will have dealings with many organizations, committees and people. Five of these will here be considered. He will be the chief executive officer of the *Mental Health Committee*, to which he will be responsible. But his task will also bring him into organic relationship with the *Board of Control* or (if its name be changed, as many desire) the Board of Mental Health. The Board might find it convenient to deal with organizations in a given area through this officer ; he would at least have to be kept informed of all regulations, administrative orders and proposals which emanated from the Board. If, further, he is concerned in ascertainment, he would have important dealings with the *Ministry of Education*.

He would further be in close touch with the *professor of psychiatry* at a Teaching Psychiatric Unit. In a closely knit psychiatric service, refresher courses and periods of post-graduate study spent at the Teaching Unit would have to be planned. Proposals for surveys and research might emanate from the Teaching Unit. The co-operation of the Medical Officer of Mental Health would be essential.

Lastly, this officer would have close dealings with the *Superintendents* of Mental Hospitals, Certified Institutions and Colonies. It was suggested in Chapter XI that the needs of an area of a million population would be met by three or four Mental Hospitals of about a thousand beds each and by two Colonies of approximately similar size. The Medical Officer of Mental Health would thus have dealings with several Superintendents. The fact should be recognized that there might here be occasions for friction, especially if the Mental Health Committee were to use the Medical Officer of Mental Health as an intermediary in dealing with superintendents who might consequently feel that their access to this Committee (which would embrace the present Visiting Committee) was less direct than formerly. The Medical Officer of Mental Health would therefore be wise if he took pains to maintain the closest and friendliest contact with superintendents, who might be asked to serve on an informal advisory group with which he could discuss, in the formative stages, matters of policy or of administrative importance. The Medical Officer of Mental Health and the superintendents should form a friendly family. The Medical Officer of Mental Health would be concerned with the co-ordination of the extra-mural activities of the area; he would have little to do with what went on inside Mental Hospitals and Colonies themselves.

The Medical Officer of Health of the Joint Authority. Another delicate matter would be the relation of the Medical Officer of Mental Health to the Medical Officer of Health.

The Royal Medico-Psychological Association has passed the following recommendation:

> 'The Medical Officer of Mental Health should be a principal officer of the Local Authority with status equal to that of the Medical Officer of Health.'

Mental health is here visualized as having an approximately equal importance to physical health: and what is in fact contemplated is an administrative diarchy. This arrangement obviously commends itself to persons who feel that the claims of mental health have in the past been pushed into the background and ignored in favour of those of physical health. The principle of diarchy may meet with approval and be regarded as workable; on the other hand, it may be felt that the health services as a whole should ultimately come under the single co-ordinated direction of a principal or Chief Medical Officer of Health, who would balance the various claims and adjust them to the available financial resources. Either arrangement would have the advantage that the mental health services would have a recognized spokesman and an authorized advocate. The Mental Health Committee of the Local Authority and its chief executive officer will put up a more closely-knit and a better-argued case than can be submitted by the four separate and largely unrelated committees which are now concerned with psychiatric matters.

Social Insurance Agencies. In Chapter XIV mention is made of how problems of mental health may present themselves to those responsible for administering Social Insurance. The Medical Officer of Mental Health may be called upon to advise or assist these officers.

Staff. It is not easy at this stage to estimate the dimensions and constitution of the staff of the Medical Officer of Mental Health. I have suggested below that each of these officers should be assisted by two full-time psychiatric social workers and a qualified occupational therapist. It would also be a good thing if he could have the services of psychiatrists on a part-time basis. It should be possible for psychiatrists to work for half their time at a Mental Hospital, Certified Institution or Colony and for the other half at various kinds of extra-mural work under the direction of the Medical Officer of Mental Health. The latter should be in a position to organize psychiatric teams for special purposes.

CHAPTER XIII

ACCESSORY SERVICES

THE survey included a question as to the use made by psychiatric clinics of accessory services. Results are shown in Tables XI and XXXIX (pp. 142 and 178). The accessory services which bear most closely on psychiatry are those provided by the psychiatric social worker, the psychologist and the occupational therapists. What further demands are likely to be made on these services in the future? And how should training facilities be organized in the light of these demands? It will be seen that, in all three services, the demand is likely to exceed the supply for some time to come. The estimates of future needs submitted in following paragraphs are therefore all reduced to a minimum.

1. Psychiatric Social Workers.

Of 192 clinics which gave relevant information, 66 (34·4 per cent) were shown by the survey to make use of psychiatric social workers. By these, it has been shown, the small-town ('B' type) clinics were somewhat better served than the large-town ('A' type), though the differences were not quite significant. 'A' type clinics, on the other hand, were better served by social workers and almoners. Can we, at this stage, form any estimate of how the demand for psychiatric social workers is likely to develop as the mental health services grow? The question can most usefully be considered in terms of where these workers will be needed, though all estimates must, at this stage, be regarded as tentative and subject to revision in the context of further experience.

Mental Hospitals. There are 101 of these in England and Wales, of which, in 1944, 27 employed psychiatric social workers.

As far as I have been able to ascertain, the staffs of 77 Mental Hospitals have undertaken out-patient work in psychiatric clinics. Some Mental Hospitals conduct more than one clinic—indeed, a few hospitals have established as many as 5—and the total number of clinics staffed from these 77 hospitals is 150. It is the practice of most of those Mental Hospitals which employ psychiatric social workers to use them for both out- and in-patient work. This is doubtless good practice; but since, in the future, Mental Hospitals will probably undertake an increasing volume of out-patient work, the dimensions of which we cannot yet measure, it will be convenient to consider the two spheres of work separately.

The activities of a psychiatric social worker on behalf of the inmates of a Mental Hospital will depend on the admission rate. A hospital of 1000 beds can be expected to admit about 200 patients a year, and to discharge a smaller number. The Association of Psychiatric Social Workers has recently (July 1944) produced a brochure on psychiatric

social work in Mental Hospitals, wherein is stressed the value of the work which a psychiatric social worker can do for patients both when they are admitted and discharged. These arguments need not be reproduced. An annual case-load of 150 admissions and 100 discharges would be a heavy one for a single psychiatric social worker; and it must be remembered that the average Mental Hospital contains more than 1000 beds. It would therefore be a very conservative estimate if we were to allow one psychiatric social worker to each Mental Hospital, and put the number required for this purpose at the round figure of 100.

Central Psychiatric Clinics. There were, at the end of 1942, 216 psychiatric clinics in the country. It is noted in Table XXXV (p. 174) that 71 out of 169 directors of psychiatric clinics (42 per cent) advocated the opening of new facilities in new areas; and it has already been remarked that the eleven teams of regional investigators, who were able to survey their regions as a whole, were fairly unanimous in thinking that the existing distribution of clinics was inadequate. Several, moreover, made specific recommendations as to where new clinics should be set up.

What, then, is likely to be an appropriate number of clinics for the country as a whole? We can do no more, at this stage, than venture a guess, but we should probably not be far wrong in putting the figure at about 320. This number would give an average of eight clinics to every million of population instead of the present figure of 5·47. At the time of the survey, Region XII (South-East) had 9·14 clinics per million; and the average figure for Regions VI, VII and XII, which comprise the south coast, was 7·75 per million. The question arises as to what proportion of these clinics should be 'central' clinics as above defined (p. 20).

In Chapter XI (p. 54) it was suggested that some 'Central' clinics should incorporate Child Psychiatric Clinics, and that these should bear a certain loose ratio to the number of Child Guidance Centres. Ten Child Guidance Centres were suggested as appropriate for a population of a million, and these would call for about three Child Psychiatric Clinics (p. 76). We should therefore probably be justified in suggesting at this stage that there would be a need for between 120 and 160 Central Psychiatric Clinics in England and Wales as a whole. These 'central' clinics would be the headquarters of a psychiatric team. How many psychiatric social workers would be needed for these clinics?

The answer to this question will depend largely on the number of patients dealt with. It is shown in Table XV (p. 146) that the average numbers of new patients received per year by psychiatric clinics depended much on their location. The averages for small-town ('B' type) clinics was 51·8; for large-town ('A' type), 114·1; and for clinics in the London area, 372. The trends revealed by the survey showed an upward rise in the course of the four years (Tables XV and XVI, pp. 146 and 150). Table XVI shows that, in 104 clinics which gave figures for all four years (from which the active London clinics were excluded because they only gave figures for 1942), the average number

of new patients per year went up from 80·0 in 1938 to 100·7 in 1942. This rise took place despite the shortages of staff and other difficulties which handicapped developments during the war; and it is further shown (Table XXV, p. 160) that a feature of the increase was the rise in the proportion of neurotic cases.

There can be little doubt that we shall see further rises, which may well become steeper when, with the end of the war, fuller medical care is available, tensions relax, the Forces are demobilized, prisoners of war repatriated and such latent neurosis as may exist in the civilian population reveals itself. The increments thus caused will broadly fall into the category of neurosis; they will present a mainly out-patient problem, and admissions to hospital will probably rise proportionately less than the numbers of out-patients.

If most of the Central Psychiatric Clinics comprise Child Psychiatric Clinics and therefore concern themselves with children, they will each require the services of at least two psychiatric social workers, though in the early stages of their development, when numbers are relatively small, one psychiatric social worker might suffice. The needs of from 120 to 160 Central Psychiatric Clinics might thus be very conservatively estimated at about 150 psychiatric social workers. But with the passage of time and the increase of 'Affiliated' clinics, such a staff would be too small. In a 5½-day week, psychiatric social workers covering affiliated clinics would probably spend about half their time in the central and affiliated clinics and half in visiting. They would need clerical help and a car. If two psychiatric social workers were employed, the posts might be graded, one worker being junior to the other, and their salaries might be adjusted to their experience.

Medical Officer of Mental Health. Some of the duties of this officer were considered in Chapter XII. These included the disposal of psychiatric emergencies and the community care of mental defectives. The amount of professional assistance which would be required by the Medical Officer of Mental Health is not easy to determine at the present stage, when his duties are undefined and when it is even undecided whether the post will exist. I can do little more than suggest that, if the post is created and if this officer is asked to discharge the duties which have been outlined in Chapter XII, he will need the help of at least two psychiatric social workers. We might provisionally put the number of psychiatric social workers needed in this sphere at 100.

Certified Institutions and Colonies. According to the Annual Report of the Board of Control for 1938, there are 129 such Institutions and Colonies in England and Wales. These had inmates as follows:

Over 1000	8
From 500–1000 . . .	8
From 300–499 . . .	19
Under 300	94

How far will psychiatric social workers be needed in these places? The answer will depend partly on the scope of the work undertaken by the Medical Officer of Mental Health, who may be asked to take

responsibility for the community care of mental defectives. It will also depend on what qualifications are felt to be needed for the work in question. The Feversham Committee considered that workers in Mental Deficiency should take 'a more comprehensive course of training on the lines of the course now undertaken by the London School of Economics for the psychiatric social worker' (para. 320). It might therefore be appropriate to attach a psychiatric social worker to Certified Institutions and Colonies with 500 or more beds. The needs of smaller institutions might be met by the services directed by the Medical Officer of Mental Health.

Child Guidance Centres. It was estimated in Chapter XI that ten of these centres would be required for every million of population. The Ministry of Education regards the services of a psychiatric social worker as necessary for each of these centres, and considers that 500 psychiatric social workers would thus be needed in this sphere.

Summary. According to the rough but very conservative estimates here put forward, there would be a need for psychiatric social workers as follows:

Mental Hospitals and large Certified Institutions . .	120
Central Psychiatric Clinics	150
Medical Officers of Mental Health	100
Child Guidance Centres	500
	870

But this may well be regarded as a minimum figure, especially when it is noted that the requirements of the Ministry of Education exceed by 130 the estimated needs of the rest of the mental health services. We should probably not be far wrong in thinking that employment could quickly be found for a total of 1000 psychiatric social workers.

Present Numbers and Training Facilities. Until the year 1944 the London School of Economics provided the only training centre. In the past the annual classes at the school have averaged about 25. But I am informed that considerable expansion is contemplated.

In the year 1944 a new training school was set up at the University of Edinburgh. I am informed that this school will be able to handle each year a maximum class of about 25 students.

The Association of Psychiatric Social Workers' list of members for 1944 gives the names of 219 persons, of whom 27 are not now employed in professional work. There remain 192 active members. It must further be recalled that the great majority of psychiatric social workers are women and that their numbers are subject to a wastage rate through marriage and other causes, including emigration from the country. This 'wastage rate' might be estimated at about 5 per cent per annum.

The present position as to supply versus demand is therefore as follows: The supply (about 190) is about a fifth of the estimated demand (about 1000). Existing training facilities, if stretched to the utmost, could add about 100 psychiatric social workers a year to the

existing number; these increments would satisfy the estimated demand in about seven or eight years. At the end of this period there may well prove to be a continuing demand arising through a widening of the channels of opportunity. But a time will come when saturation point is reached, though, as far as we can predict at present, that time is likely to belong to the comparatively remote future.

The question thus arises of whether the supply should be enlarged by increasing the number of training schools. There is a *prima facie* case for establishing a new school at an energetic centre of psychiatric and sociological activity at a University in the Midlands, such as Liverpool or Manchester. The regional investigators who conducted the neurosis survey in Region VIII (Wales) have also stressed their region's need for social workers and psychiatric social workers who can speak Welsh. The implication of this plea is that a school be started in Cardiff. The establishment of new schools is a matter which primarily concerns the Universities. The main need is for vigorous and progressive schools of Psychiatry and of Social Science. But a caveat is here needed. The London School of Economics has set a high standard in psychiatric social work. This fact is universally acknowledged, and need not be stressed except perhaps in one respect. An important feature of the school's procedure is the process of selection to which candidates are subjected at the outset. Each candidate is interviewed separately by three members of a committee—the tutor to the course, a psychiatrist and a psychiatric social worker with experience of the requirements of the course. These three persons assess the candidate's fitness for the work she will be called upon to do. The standards are strict, and about two candidates in three are rejected. The committee rejects candidates whose personality is unsuited to the work and those who want to take it up as an outlet for private stresses or emotional difficulties. This arrangement minimizes the number of candidates who are failed at the end of the course; but it presupposes that candidates are in excess of the available vacancies.

There is an obvious danger that, in an effort to meet the urgent demands of the mental health and education services for more psychiatric social workers, standards may be lowered. This would be an unfortunate occurrence. The very high value which is to-day placed by all on the work done by the psychiatric social worker is in large part due to the excellence of the type and of the training. It would do much harm to the social development of psychiatry if, in the multiplication of training schools, either of these standards were lowered. A good way of preventing the development of too wide a diversity of standard would be to have a common examination system. But such an arrangement would require to be carefully thought out. Most universities have regulations governing their examinations which make them self-sufficient. A disadvantage of this arrangement is that specialist diplomas vary much between universities, as the Goodenough Committee recognized when it made recommendations to minimize these disparities.

2. Psychologists.

The rôle of the psychologist in the mental health services of the future has been discussed in Chapters IX and XI (pp. 52 and 73). The problem which here arises is more difficult than that presented by the psychiatric social worker because the work of the psychologist enters into other spheres than that of mental health. It is particularly involved in the education services, and there is little doubt that more psychologists will be employed in the latter services than in those connected with psychiatry. Much therefore depends on the views taken by the Ministry of Education as to the part which psychologists should play in the education services.

It has earlier been suggested (Chapter IX, p. 53) that the Child Guidance Centre might be regarded as the headquarters of a psychologist working on an area basis; and that if the psychologist were to undertake the full duties suggested, the maximum number of school children with whom she could deal would be about 20,000. By a 'child' is meant a person included within the range of ages (from three to sixteen and over) covered by the Education Act. The limit will go up when the school-leaving age is raised and perhaps when County Colleges are in operation. We are thus fairly safe in regarding about a fifth of the country's population as children in this sense. Their numbers in England and Wales can be put at approximately eight million. If one psychologist were to cover 20,000 children, some 400 psychologists would be needed to meet the needs of the country as a whole.

A Committee of Professional Psychologists (Mental Health), whose chairman is Miss L. G. Fildes, has recently (1944) been formed under the auspices of the British Psychological Society. A memorandum on the qualifications, training and prospects of psychologists has been produced by this Committee, which includes an outline of the training course which has been approved. The qualifications are divided into general and special. The general qualifications require: (*a*) an honours degree in psychology or its equivalent; (*b*) a minimum of two or three years' teaching experience with children, or an acceptable alternative which would probably include certain types of service in the Forces; and (*c*) a suitable personality. The special training consists of a minimum of six months' experience (a full year's would be preferable) in a selected Child Guidance or Child Psychiatric Clinic. The experiences to be gained in the six months' or year's special training include: (*a*) the administration and organization of child guidance services and of the teamwork therein involved; (*b*) the educational, social and medical services for children, including visits; (*c*) work with normal and abnormal children, including the pre-school child and the adolescent; (*d*) courses in the mental testing of children of all ages and the appropriate forms of report and recommendation submitted to individuals and authorities concerned; (*e*) the method and practice of remedial teaching; (*f*) the method of selecting children for education suited to their age, ability and aptitude; (*g*) the organization of, and educational methods to be employed in, classes for dull,

backward and problem children; (*h*) and/or, in addition to (*g*), vocational guidance for persons referred to the clinic services.

It will be seen that the programme of special training is extremely detailed and comprehensive, and that six months is a short period during which all these subjects could properly be covered. It will further be appreciated that much care will be necessary in selecting the Child Guidance or Child Psychiatric Clinics which are to be recognized as eligible to provide for this comprehensive training. The example of the London School of Economics in appointing a full-time tutor who gives, as part of her duties, individual tuition to pupils, might well be followed.

The question of vocational guidance also calls for careful attention. Current practice in this sphere differs throughout the country. In 104 Local Education Authority areas, the Juvenile Employment Service is administered by the Local Education Authority; but in the other 211 it is administered by the Ministry of Labour and National Service with the assistance of some 250 Juvenile Advisory Committees. As the technique of vocational guidance is developed, important new spheres of work demanding special knowledge and experience are likely to open for psychologists.

Enough has been said to show that the demand for properly trained psychologists is likely to be great and that the standards set for them are high. What about the supply?

The existing supply is small and the present prospects of its being rapidly increased are also small. The present membership of the Committee of Professional Psychologists (Mental Health) is between seventy and eighty.

At present some ten or twelve psychologists receive in each year the special training above described. But facilities could be expanded if financial help were made available.

There is here, in my opinion, the most serious bottle-neck of any that affects the essential and accessory services concerned with mental health. There is the same danger that confronts the training of psychiatric social workers—that the urgent need for increased numbers will lead to a temporary lowering of the standards affecting general qualification and special training. This matter requires careful examination by an appropriately constituted committee which would include representatives of the Ministries of Education, of Health and of Labour and National Service. A new and interesting profession is being opened by developments in education, mental health and industry. Some expenditure of central funds may be needed to improve training facilities and to remove financial obstacles standing in the way of the right kind of student.

3. Occupational Therapists.

How should we define an occupational therapist? The term can be strictly understood in terms of the possession of a diploma or certificate. The Association of Occupational Therapists gives a diploma; and the Royal Medico-Psychological Association has

instituted an Occupational Therapy Certificate for those holding mental nursing certificates. Or the term can be generally interpreted to cover a person who, without having obtained a recognized qualification, has taken an interest in the subject and has experience of practical work in a hospital or institution. Many persons now conducting occupational therapy with apparent success belong to the second group. It is not easy to estimate how many such persons are available.

But a need for some system of training has been officially recognized. To meet the demands which have arisen from the war and from the recent development of rehabilitation services, new qualifications have been introduced and examinational standards set. In an ascending order of their stringency, these qualifications are: (1) the auxiliary qualifications; (2) the 1943 certificate; (3) the War Emergency Diploma for those with prerequisite qualifications. The Association of Occupational Therapists hopes to regularize the position created by these less exacting qualifications by a system of credits which will make them stepping-stones towards the full diploma. This is reserved for members of the Association who have passed the final examination and completed the necessary practical work which involves, in all, about two and a half years' study.

The psychiatric aspects of occupational therapy can be discussed from three standpoints: (i) the estimated need for occupational therapists in the psychiatric services of the future; (ii) the present training facilities and the numbers of workers now available; and (iii) measures for adjusting supply to demand.

(i) ESTIMATED NEEDS.

Mental Hospitals. There is general agreement among superintendents that all mental nurses should help to direct the patients' occupational activities. Superintendents oppose a degree of specialization which results in these activities being regarded as the exclusive monopoly of a highly trained expert, and therefore outside the sphere of the rest of the hospital's staff. At the same time it is widely agreed that every Mental Hospital should have the full-time services of a qualified occupational therapist. In addition to her work with individual patients, this officer is in a position to provide training for the nursing staff in occupational methods and to organize and supervise the provision of occupational therapy in the wards and on a group basis.

At present some 30 Mental Hospitals employ a qualified occupational therapist. If every Mental Hospital were thus served, there would be a need for 100 occupational therapists.

Medical Officers of Mental Health. If these officers are to be responsible for the community care of the mentally infirm, including the provision of occupation and handicraft centres, they may well find it useful to have the assistance of one or more occupational therapists whose work would be in part peripatetic. If each Medical Officer of Mental Health were to employ two or three occupational therapists, there would be a need for about a hundred of these workers.

Certified Institutions, Colonies, Registered Hospitals, etc. We are here on difficult ground. Certified Institutions vary much in size, organization and practice. Occupational activity plays an essential part in their daily routine, and at least three employ a qualified occupational therapist. Several of these workers are also employed in Registered Hospitals and in hospitals, other than Mental Hospitals, which deal with psychiatric cases. But it is now hardly possible to estimate future needs in these spheres.

Psychiatric Units. It was suggested in Chapter XI that, for a start, 100 beds per million of population be provided in Psychiatric Units. These units will be active, and will need the services of occupational therapists. We might allow as a minimum for this purpose one occupational therapist to each area of a million, and put the number for the country as a whole at 50.

We might thus tentatively predict that there will be a need in the psychiatric services for about 250 occupational therapists, though many more could, in due course, be usefully absorbed.

(ii) EXISTING TRAINING FACILITIES AND SUPPLY.

The Association of Occupational Therapists was established in 1936. There are now (1944) 129 full members and 193 associates; of the latter some 13 per cent are neither occupational therapists nor students, but consist of people interested in the work. Fifty-four members and associates are now working on the psychological side. The training course lasts two and a quarter years, of which the first half is spent at a recognized training centre and the second at an approved hospital where practical experience is gained. At the end of the first or preliminary period, an examination is taken, and on the completion of the course, a final examination. Very detailed and elaborate curricula for both examinations have been laid down by the Association. Before the end of the preliminary period of her training, the student decides whether she wishes to devote herself to physical or psychological work, and the choice of hospital for the second half of the course depends on this decision. It is possible for students to take a dual training in both physical and psychological aspects of the work—a policy which should surely be encouraged. The full cost of training, including examination fees, is between £150 and £200, though special allowances are sometimes made; and the training for the shortened courses, instituted since the war, is largely free. On satisfactory completion of the courses and of the examinations, a diploma or, for the war qualifications, a certificate is given. The students show a slight preference for the physical rather than the psychological side of the work: about two-thirds opt for the former.

There are at present four training schools. They are situated in London (12 Merton Rise, N.W. 3), in Northampton (St. Andrew's), in Bromsgrove, Worcestershire (Dorset House School), and at Exeter (St. Loyes, not yet recognized). Other schools are likely to be founded. The annual training capacity of these schools is at present about 150.

In addition to the 129 full members and 193 associates above mentioned, there are now (September 1944) occupational therapists qualified according to standards set by the Association, as follows :

Auxiliary Qualification	53
1943 Certificate	28
War Emergency Diploma	79

Candidates are interviewed by the Principals of the training schools before being accepted for the course. Rejections vary from year to year, but average about 30 per cent. There is a big surplus of female candidates over male, and the Association would be glad if more men applied to take the course. But the scale of salaries (maximum £375 a year) presents difficulties here. A salary scale has been laid down by the Association.

(iii) MEASURES FOR ADJUSTING SUPPLY TO DEMAND.

There can be little doubt that, with the growth of national rehabilitation services running parallel with, or as part of, the national health services, the demand for qualified occupational therapists will increase. I have estimated the need in the psychological sphere at a minimum of 250, though there are likely to be openings for many more. The need in the sphere of physical medicine will certainly be larger than in the psychological.

The demand of would-be students for training in occupational therapy is increasingly in excess of the available training facilities. The training school in London has already received applications from more candidates for 1945 than it has places for. It can therefore be said that for some considerable time, existing training facilities are unlikely to satisfy either the demands of employing organizations for trained workers or of candidates who want to be trained.

Existing facilities thus form a bottle-neck between a large supply of candidates for training and a large demand for trained workers. I have visited the training school in London and am satisfied that, in the premises they now occupy, there is no room for expansion. It would therefore seem appropriate that the existing position in respect of the following matters be examined by an officially appointed committee with powers to make recommendations :

The need for a qualification and for examinational standards in occupational therapy.

Appropriate curricula for physical, psychological and 'dual' qualifications in occupational therapy. Consideration might here be given to including in the curriculum more outdoor activities. These are not included in the Association's present syllabus which, in other respects, is very elaborate indeed. The average gardener can provide occupation ; but he lacks medical and psychological discernment and cannot apply his special knowledge therapeutically.

The demand of candidates for training, the demand of hospitals, institutions, etc., for trained workers and the relation of both demands to existing and likely future training facilities.

The salary scale, with special regard to attracting more men to qualify for this profession.

Such an official committee might include representatives of the Ministries of Health, Labour and National Service, Pensions and Education, as well as at least one person with intimate knowledge of occupational therapy. The Ministry of Education is made responsible, under the Education Act, for providing special schools for children who are in various ways physically handicapped and educationally subnormal. In these schools there may well be a need for occupational therapists.

After the matters above mentioned have been fully investigated, it might be found that there is a need for an officially recognized and perhaps centrally subsidized school with a larger capacity than any now existing ; or it might be thought desirable to establish recognized relations, for purposes of the first as well as for the seond half of the training, with certain approved hospitals.

Conclusion. In the three most important accessory services, bottle-necks exist in the existing training facilities. Demand, supply, and training facilities should be investigated in all three by an officially appointed committee containing representatives of the Ministries concerned.

CHAPTER XIV

PREVENTION OF MENTAL INFIRMITIES: THE SOCIAL PROBLEM GROUP

In every mental infirmity, whether of major or minor character, both genetic and environmental factors play an interacting part. National Insurance, family allowances, comprehensive health and rehabilitation services, better education and housing, will provide a better environment. The social conditions of the bulk of the population will be improved. Sir William Beveridge's five 'giants'—of disease, ignorance, squalor, idleness and want—will be attacked; and the establishment of a national minimum will be the aim. It is the avowed policy to reduce, by every means possible, the environmental factors which contribute to physical and mental disease.

In addition to these measures, a psychiatric service emphasizing prevention rather than cure should further reduce the extrinsic causes of mental infirmity. The proposals submitted in the present report are thus framed; they are much concerned with children and with measures for the earliest possible detection among them of deviations from normality.

Much is thus being done to reduce the environmental causes of mental disorder and defect. What about the genetic causes? In the measure that the environment is improved, these will be brought into prominence. How important are they? And how can they be dealt with?

The Wood Report, a document whose importance has not been fully recognized, makes a noteworthy contribution to this topic. From the administrative standpoint, its most important recommendation was that the higher grades of mental defect should, for educational purposes, be treated as part of a wider grouping of 'retarded' children (Part II, Chapter VIII). 'The scheme we propose', say the Wood Committee, 'involves to some extent a fresh orientation . . . and a fresh terminology.' The fresh terminology applies particularly to the meaning given to what the Committee calls the 'retarded group' of children for whom special education is advocated. This group embraces not only children who are of subnormal intelligence, but also 'a certain number of children who are mentally defective in the sense in which that term is used in the Mental Deficiency Acts, *i.e.* incapable of independent social adaptation, and who will subsequently require to be notified to the Local M.D. Authority' (Part II, para. 149, footnote). 'The whole group of retarded and higher grade defective children in fact present a single educational problem. . . . The anchorage, indeed, of the educationally defective is rather with the dull or backward than with the socially defective' (Wood Report, Part II, para. 105). The retarded group 'consists broadly of all children who though educable in a true sense are unable to profit from the instruction in the Primary Public Elementary Schools as these are

now generally organized' (Part II, para. 106). The Committee goes on to say:

'There is yet a further reason which renders it essential for us to consider this marginal group. The two groups of mentally defective and retarded children are not merely contiguous groups; there is scientific ground for thinking that a causal relation exists between them. The findings of our investigation . . . point to the conclusion that the majority of the feeble-minded are to be found within a relatively small social group, a group which may be described as the subnormal or social problem group, representing approximately 10 per cent of the whole population. Most of the parents in this subnormal group are themselves of poor mental endowment, and would no doubt have been classed, when children, among the dull or retarded. Similarly the dull children of the present generation, who form a large majority amongst children in this subnormal group, are the potential parents of many feeble-minded in the next generation. Therefore, from the standpoint of the prevention of many social evils it is of the utmost importance that the problems of the education and social care of the borderline retarded child should be effectively tackled.'

There is one last passage which, though fairly well known, I will quote from the Wood Report:

'Let us assume that we could segregate as a separate community all the families in this country containing mental defectives of the primary amentia type. We should find that we had collected among them a most interesting social group. It would include, as everyone who has extensive practical experience of social service would readily admit, a much larger proportion of insane persons, epileptics, paupers, criminals (especially recidivists), unemployables, habitual slum dwellers, prostitutes, inebriates and other social inefficients than would a group of families not containing mental defectives. The overwhelming majority of the families thus collected will belong to that section of the community which we propose to term the "social problem" or "subnormal" group. This group comprises approximately the lowest 10 per cent in the social scale of most communities' (Part III, para. 91).

The Wood Report was published in 1929. Fourteen years later the social problem group (whose features, while always familiar to persons concerned with the social services, have been little recognized by the general public) again attracted the limelight of publicity. The occasion was provided by the evacuation of children from bombed areas. Here is an extract from a report on the subject:

'The effect of evacuation was to flood the dark places with light and bring home to the national consciousness that the "submerged tenth" described by Charles Booth still exists in our towns like a hidden sore, poor, dirty, crude in its habits, and an intolerable and degrading burden to decent people forced by poverty to neighbour with it.

'Within this group are the "problem families" always on the edge of pauperism and crime, riddled with mental and physical defect, in and out of the courts for child neglect, a menace to the community, of which the gravity is out of all proportion to their numbers' (*Our Towns: A Close-up.* O.U. Press, 1943).

The social problem group not only confronts us with difficulties to-day; it will also preoccupy the legislator and social reformer of

to-morrow. For it has another characteristic not mentioned in the above quotations but nevertheless recognized by the Wood Committee (Part III, para. 93)—namely, an abnormally high fertility.

If we accept the views of the Wood Committee as to the part played by the social problem group in generating mental disorder and defect—and the very painstaking investigations on which their conclusions are based can leave little doubt of their general validity—noteworthy consequences ensue. The most important of these is, in a broad sense, demographic and psychiatric. The population of this country is now failing to replace itself. But the contribution to the next generation made by its constituent elements is unequal. If the social problem group, forming about 10 per cent of the population, is the principal seed-bed of mental aberrations, if the fertility of this group is, in fact, higher than the average, and if its characteristics are in part genetically determined, we can reasonably anticipate an increase of mental infirmities in the future, though the promised improvement in social conditions may mitigate this effect. The important and delicate question thus arises of what are the causes of this high fertility.

These causes are intimate and personal. The future of this country and indeed of the world as a whole will depend much on demographic trends. These can be discussed in highly mathematical terms and interpreted in various abstract ways. Yet it has been truthfully and tersely said that they are all ultimately reducible to what happens in the bed.

There is no doubt that the decline of fertility in what are broadly called western countries has been mainly caused by the spread of birth control. But the use of all preventive methods call for a certain minimum of foresight and prudence, and it results in what has been called the planned family. Where these prudential qualities are absent, there result large families which are mostly unplanned. The taking of a family or reproductive history by a psychiatrist or gynaecologist to-day involves a more detailed inquiry than formerly; information is usually now sought on the question of whether the relevant pregnancies were planned and intentional or unpremeditated and accidental. There is much information on this subject in existence already, but most of it is unpublished; more will be available in the future. There is no doubt that the high fertility of persons comprising what the Wood Committee called the social problem group is mostly due to a sequence of unplanned and essentially unwanted pregnancies, an unduly large proportion of which end in miscarriages or abortions. 'Two common types in this group', says the Wood Committee, 'are the unmarried woman of child-bearing age admitted two, three or more times to the maternity ward of the workhouse, and the recidivist of the criminal classes. These two types alone are the parents of a not inconsiderable number of the mental defectives who become social dangers and economic burdens; and probably this is the most serious offence of these parents against the community' (Part III, para. 94).

How best to restrict the harmful activities and the fertility of the

social problem group is one of the most obstinately difficult and refractory problems confronting the political reformer. While primarily challenging the social scientist, the conundrum also presents itself to the psychiatrist in the measure that mental infirmities—mental defect and subnormality, psychosis, neurosis, epilepsy, recidivism, delinquency, inebriety—enter into his sphere. What is to be done with these people? They circulate from hospital to public assistance authority to voluntary and charitable organization until their names are notorious. Attention was drawn to them by problems of evacuation. At the time of writing (July 1944) they are again attracting notice in connection with the minor looting and pilfering of houses destroyed by flying bombs and of collection-boxes in bombed churches. There being no satisfactory means of disposal, these families present a continuing problem. Imprisonment for such as are recidivists has little deterrent value; and attempts at psychotherapy are a waste of time.

There is no simple or single solution. But the position is not hopeless; indeed, the social changes which are impending hold out more promise than has been afforded in the past.

It is clear that the provision of a national minimum and of a comprehensive scheme of social security will lend itself to grave abuses. Machinery will have to be created to check the careless admission of claims and the irresponsible distribution of benefits. In the words of a recent leading article in the *British Medical Journal*: 'The dilemma of the social planner is . . . to bestow benefits without encouraging the idler, the spendthrift and the malingerer, and without sapping the initiative of the country's manhood: the free gift of *panem et circenses* to the Roman populace was a policy characteristic of the decline and not of the rise of the Roman Empire.' While the vast majority of people can be counted on to behave honestly and straightforwardly, there will be a small minority whose characteristics are well known to persons experienced in administering charities, who will resort to various devices to obtain benefits to which they are not entitled. In each area there will be certain notorious families.

How can the activities of these families be recognized? The White Paper on Social Insurance provides an effective answer. Paragraph 37 deals with the necessity of compiling a register of insured persons. It says:

> 'Under the new scheme it will be necessary to obtain and classify information about the whole population so as to enable every person to be placed in his or her appropriate insurance class. After that it will be necessary to compile and maintain one or more central registers, in which the insurance record and status of every insured person will be entered and kept up to date. The register will be an essential feature of the scheme for several reasons: first, to record classification and transfer between classes; second, to facilitate the enforcement of payment of contributions; *and third, so that the record of any insured person in relation to contribution and benefits can be ascertained when necessary.* The task of compiling and maintaining such a register is obviously one of the first magnitude, but it is an unavoidable step and one which must ultimately promote efficiency and economy.' [My italics.]

In paragraph 11, moreover, this White Paper insists on the need for ' strict administrative economy in every sense. . . . All pay into the fund ; all must be its custodians.'

These central registers are obviously capable of yielding very detailed and comprehensive information about the Wood Committee's social problem group. This Committee's investigations were painstaking and detailed, and they covered six different areas of the country. Nevertheless, it would be wise to regard the existence of a social problem group as described by the Wood Committee as not yet finally proved, and to look to the central registers proposed by the White Paper as a means by which conclusive evidence could, in time, be obtained.

Such a course, however, demands of those who compile the registers a consciousness of the problem and of our need for further information. An enormous mass of data will be accumulated in these registers. There is a risk that much of it may be consigned to files where its significance may be overlooked. Social problem families may well attract attention primarily for reasons of accountancy ; they will affect the economics of national insurance. Less directly, however, they have importance for psychiatric, genetic and demographic reasons. Hence the organizers and compilers of these registers should know what is meant by a social problem family, and should be encouraged to collect such information as presents itself according to methods which admit of tabulation, co-ordination and analysis. From many standpoints the results will have interest, among them that of preventive psychiatry.

The first step is to recognize these families and record their distinctive features ; the next is for some responsible authority to deal with the family's problems. If a large, unwanted and socially burdensome fertility is one of the features, certain steps should be taken. The mother and also the father should be referred to some centre which deals with family problems—a health centre, a maternity and child welfare centre, a branch of the Family Planning Association. Here the reproductive history would be investigated and the causes of unwanted pregnancies ascertained. Appropriate advice would be given in the light of the mentality, the financial resources and the religious persuasion of the couple concerned.

In a small proportion of cases, facilities for voluntary sterilization would be welcomed. There are reasons, not yet made public, for thinking that the voluntary sterilization of people who are not certifiable as of unsound or defective mind is not attended by such serious legal difficulties and risks as have hitherto acted as deterrents. The propriety of sterilization for genetic reasons was discussed by the Wood Committee (1929) which, while ' not prepared to deny that this measure might under adequate safeguards prove of value in a very limited number of individual cases ' (Part III, para. 98), gave no general support to the measure. In the last fourteen years, however, there has been a change of view. Opinion was influenced by the publication in 1934 of the report of a departmental committee on sterilization under the chairmanship of Sir Laurence Brock. This document, generally known as the Brock Report, recommends that voluntary

sterilization for certain categories of mental disorder and defect and of physical disease, be legalized subject to certain specified safeguards. Its recommendations have not resulted in legislative action, though a number of sterilizing operations have since been performed at the request of patients falling within the categories specified by the Brock Committee, and in general conformity with the safeguards it advocated. There have been no legal difficulties.

However searching the 'ascertainment' of these families and however enlightened their handling, there will remain a residuum upon whom all efforts are wasted. Of this character are likely to be certain petty recidivists of subnormal mentality who are chronically in and out of the courts; also certain mentally subnormal drink addicts. Reference was made above to the occurrence of unwanted pregnancies among members of the social problem group. It is a fact well appreciated by all persons who have taken detailed reproductive histories that there is a close connection between the occurrence of unwanted pregnancies and addiction to drink. This connection is here mentioned because of its very great and unrecognized social importance. That there is a close connection between inebriety and various social evils—such as road accidents, crimes of violence and the spread of venereal diseases—has long been appreciated; the occurrence of unwanted pregnancies is not generally recognized as an item in the list. Yet this probably happens more often in the Wood Committee's social problem group, whereof inebriety is a recognized feature, than in any other social element.

What, then, is to be done with this obstinately refractory residuum? A proposal has been put forward by Norwood East and jointly by East and Hubert, both high authorities on recidivism and criminal psychiatry, that for this group colonies should be established combining some of the features of a hospital and a prison. Such a 'social rehabilitation' centre or colony would have a therapeutic rather than a penal outlook, and would be especially appropriate for recidivists of low mentality who are unaffected by punishment and inaccessible to psychotherapy. These places would be run on lines generally similar to those followed in colonies for epileptics and high-grade defectives, and would share with them a system of licence. This proposal has been under discussion by the Home Office (Report of the Commissioners of Prisons and Directors of Convict Prisons, 1938, p. 50), and merits further examination. If, after schemes for a national minimum and social security are in operation, the residual group in question is still found to present social problems, it might be made the subject of a special inquiry by an inter-departmental committee or even by a larger and more representative body. The Magistrates' Association would give valuable evidence.

It has further been suggested that many 'social problem' people of subnormal mentality could be dealt with under the Mental Deficiency Act, 1927, if Section 1 (2) were modified. This reads:

'(2) For the purpose of this section, "mental defectiveness" means a condition of arrested or incomplete development of mind existing before

the age of 18 years, whether arising from inherent causes or induced by disease or injury.'

It is not always easy to prove of an adult, of whom little is known, that the defect was present before the age of 18.

One further agency must be mentioned which would counteract the bad influence of the group now being considered—the nursery school. This remedy is strongly favoured by the group which produced the report on evacuation above quoted. The nursery school will play a recognized part in the educational framework of the future; it forms part of the structure delineated in the Education Act (Section 8 (2) (*b*)). The influence of the nursery school can do something to counteract, in the mind of the growing child, the effects of squalor in its home life. And perhaps more important, it can exert a valuable educative influence upon the parent. If at the end of the day the child is returned to its home happy, well-fed, tidy and clean, a standard is set in the child's mind in relation to which it can form the rudiments of a judgment of its home; and a standard is set for the parents in respect of which they will be anxious not to be found wanting. As nursery schools develop and gain experience, it will be interesting to know what proportion of parents is found incapable of profiting by the example set and the lesson taught by the school. It may well be found that the proportion is lower than might be expected.

CHAPTER XV

MISCELLANEOUS

1. Records.

Statistics, weekly and monthly returns, and forms requiring completion are widely regarded as the weapons with which the bureaucrat wages war on the clinician. Among the forebodings to which the prospect of a state medical service gives rise is the picture of an official hierarchy which demands placation not by the maintenance of high clinical standards but by the meticulous discharge of clerical duties. Behind a smoke-screen of punctually returned and correctly filled-in forms, mediocrity is visualized as entrenching itself. The fact is sometimes lost sight of that a good clerical service is indispensable for efficiency. When case-sheets are mislaid and relevant documents cannot be found, the patient suffers and the doctor is exasperated and frustrated.

In every clinic, moreover, annual reports are called for; changes cannot be measured unless adequate records are available; and research based upon past work is hindered if the relevant information is not to hand on the case-sheets. And in the future, efforts will doubtless be made to evaluate the development of the medical services. The Wood Committee was confronted with the question whether mental deficiency had increased; and the neurosis survey which I have carried out was in part designed to throw light on the effects of war on the volume of neurosis. Similar problems will confront us in the years to come. If attention is focused on the preventive side of medicine and if public money is spent upon the organization of preventive services, the public will have a right to know how effectively these services are working. Answers cannot be provided unless appropriate records are kept.

The case-sheets and records system at present used in the psychiatric clinics of the country show a wide variation. The range is from the clinic which uses no formal case-sheet, the doctor making what notes he likes on a blank piece of paper which may or may not be kept, to the clinic which uses for each patient several elaborate sheets, each with many headings, and which makes elaborate arrangements for the compilation and filing of records.

The clerical arrangements and records system needed at psychiatric clinics vary with their size, their complexity and the requirements with which they have to comply in respect of annual and other reports. In a clinic with few patients per year, simple clerical arrangements are compatible with efficiency. But complications are introduced by any one of the following four factors: large numbers of patients; the possession of psychiatric beds by the hospital which contains the out-patient clinic, so that there is a traffic between in- and out-patients; responsibility for 'affiliated' clinics which are staffed by a visiting

team based on a 'central' clinic; and the possession of a separate department for children. Indeed, psychiatric clinics can be grouped into types depending on the complexity of their organization. But all clinics are confronted with certain common problems, of which one depends on the continuity with which their patients attend. A patient may visit the clinic once and no more; he may make one or more consecutive return visits in the course of the year during which he first attended and in subsequent years; he may be discharged or cease to attend for a period long enough for him to be written off, and then, at a later date, reappear as a 'new' patient; if the clinic deals with children in a separate department from adults, a patient may begin his attendance as a child and continue as an adult. In all these cases the clerical arrangements should be such that the relevant documents are kept up to date and ready to hand; and such figures as are periodically required should be producible with the minimum of effort and delay.

General files can be kept in alphabetical, numerical, chronological or diagnostic order. Each serves a particular purpose and fills a special need.

A commonly followed and useful practice is to keep the case-sheets themselves in a numerical order. Each new patient, on his first attendance, is given a number, as is a recruit on joining the Army, which he retains during the rest of his attendance at the hospital. These numbers are given in the chronological order of the patients' first attendances. Since many patients forget their numbers or else lose the out-patient attendance card on which their numbers are registered, there is (unless the numbers of out-patients are small) a further need for an alphabetical file, whereon the patient's out-patient number is entered.

The alphabetical file is best kept as a card index. On each card are entered such particulars as are necessary to identify the patient's case-sheet. Among these, his date of birth and full Christian names are essential, to which can be added the years during which he attended the clinic and, if desired, the dates of admission as an in-patient. If full Christian names are not entered, confusion can arise over long periods with commonly occurring names. Provision should also be made, by cross-filing, for women changing their surnames after marriage.

A chronological file of attendances is best kept in a day-to-day register of new and return attendances, for which the sister in charge of out-patients or a registry clerk is responsible. The figures required in annual and other reports can be consolidated from week to week and from month to month with very little effort if a definite routine is established. From these consolidated figures, annual or other periodic figures giving numbers of new patients, of total patients and of total attendances can be quickly compiled as required.

A diagnostic file is useful for purposes of research and retrospective surveys. This file presents more difficulty than the others, and should be based on an approved classification of psychopathic conditions. Again, the card-index system is the best: each card should record the

patient's name and number, to which can be added whatever additional clinical information is thought desirable.

When patients are numerous, the accumulation of material over years is great, and various arrangements are adopted for storing papers of patients who have died or else ceased to attend for a specified length of time. But provision has to be made for a patient turning up again after a lapse of years. For clinics which deal with specific aggregations of patients—as from large factories in an industrial area, or patients engaged in special industries or occupations—supplementary files or (in a register) indices can be devised in appropriate ways. Or else a system of punch cards can be used, whereby patients falling into various clinical, social, occupational or age categories can be quickly separated from the total aggregate. The psychiatrist can thus arrange his categories in accordance with any programme of research or type of survey in which he may be interested. It is needless to say that the person in charge of records, whether a specially appointed registry clerk or the sister responsible for out-patients, should be carefully chosen. The mildly obsessional type which is scrupulous about detail and method is here useful; and adequate arrangements should be made for her replacement during holidays or illness.

We may now consider four types of clinic in an ascending order of complexity.

(*a*) THE 'INDEPENDENT' OUT-PATIENT CLINIC WITHOUT BEDS.

This is the simplest type of clinic, for it has no in-patient department and no affiliated clinics. The 'records' problem here presents no complications. Comprised in this group are clinics set up independently of hospitals by voluntary psychiatric organizations and institutes. Some of these deal with large numbers of patients and keep very careful records.

(*b*) THE CENTRAL CLINIC, WITH AFFILIATED CLINICS BUT NO BEDS.

Here a psychiatric team based on a central clinic makes periodic visits to one or more affiliated clinics. If the records are kept at the central clinic, certain complications are introduced which require careful thinking out if confusion is to be avoided. If an appointment system is in operation at the affiliated clinics, the psychiatric social worker knows what new and old patients to expect, and can take the relevant case-sheets with her when she attends sessions at the affiliated clinic. But the possibility arises that, through a mistake or by reason of some circumstance of urgency, a patient may turn up without an appointment. The psychiatrist then finds himself in difficulties if the case-sheet is not available. The difficulty is aggravated if the psychiatrist who is familiar with the case is absent on account of illness, holidays or some other cause, and his patients are seen by a colleague. An alternative arrangement is for a clerk or psychiatric social worker to take the case-sheets back to the central clinic after the first visit of a new patient; here the psychiatrist may dictate a letter to the patient's doctor and the necessary entries are made in the supple-

mentary files. The case-sheet is then returned to the affiliated clinic and kept there until the patient is discharged. After the patient's first visit, relevant notes as to return attendances can be conveyed by some approved routine to the registry, and entered in the central register and files ; or other arrangements can be made in accordance with general convenience and with the psychiatrist's habits in writing to the referring doctors. He may either dictate the letter there and then at the affiliated clinic, or later at the central clinic, or in his own home.

Similar considerations would apply to a child psychiatrist based on a Child Psychiatric Clinic, who visits peripatetically Child Guidance Centres. The latter, from the psychiatrist's standpoint, might be regarded as ' affiliated ' to the Child Psychiatric Clinic.

(*c*) THE ' INDEPENDENT ' CLINIC WITH BEDS BUT NO AFFILIATED CLINIC.

Here a two-way traffic has to be allowed for between the wards and the out-patient department. Most of the London teaching hospitals are in this position. They have active out-patient departments and also a small number of beds into which selected patients are admitted. Before the war, few had affiliated clinics. The arrangements as to records here depend much on the system which prevails in respect of in-patients in the hospital as a whole. Papers relating to discharged in-patients are often kept separate from the case-sheets used for current out-patients ; and the files for discharged in- and out-patients are sometimes stored in different parts of the hospital. There is generally no difficulty about the case-sheet being conveyed from the out-patient department to the ward ; but arrangements for returning it, together with the patient's records as an in-patient (or else with a summary of the findings and results of in-patient treatment), are more difficult to safeguard. An in-patient, moreover, who is taken in directly, without first attending as an out-patient, and who does not subsequently attend as an out-patient, may not be given an out-patient number, and may thus be omitted from a file which is intended to comprise both in- and out-patients.

Since special notice is usually taken of in-patients in annual and other reports, it is desirable to standardize a method by which, in the registers and files, in-patients can be quickly separated from the total aggregate of patients.

It should be made somebody's clear duty to supervise and co-ordinate the records of both departments.

(*d*) THE PSYCHIATRIC UNIT WITH BEDS AND AFFILIATED CLINICS.

This is the organization which, in earlier sections of this report, has been visualized as forming the basis of the extra-mural psychiatric services of the future. The routine compilation of records presents considerable difficulties, and these duties should be placed in the hands of a carefully chosen person who can be understudied in case of need. Certain rules must be laid down for the admission as in-patients of cases seen at affiliated clinics. The preparation of a waiting list,

graded as to priorities, the notification of the patient or relatives of the date and procedure of admission, the collection of case-sheets kept at the affiliated clinics, the reception and disposal of the patient on admission, and the transmission of the case-sheet to the ward—all these involve routine duties for many people ranging from the director of the unit to the hall porter. And reverse procedures follow a patient's discharge: summaries must be prepared by the doctor in charge; the case-sheets must be collected from the wards, and various entries made in registers and files. A letter may be sent to the patient's doctor. Lapses or omissions can creep in at many points and cause difficulties and irritation when returns are compiled.

But if routine duties are carefully drawn up and allocated to the people concerned, if responsibilities (both executive and supervisory) are defined and appropriately distributed, and if the right people are chosen for these tasks, omissions and mistakes are reduced to a minimum. The format of case-sheets and the methods of filing and tabulation, if carefully planned, can be made readily adjustable to such special requests for information from central authorities as may be needed to elucidate trends in the mental health of the nation. As remarked in Chapter IV (pp. 14–17), standards are now so variable and existing facilities so unequally used that a well-grounded conclusion on general trends is difficult to reach. A point on which information is sure to be needed is how far medical practitioners avail themselves of developing psychiatric facilities. This information should not be difficult to obtain. The names of doctors practising in the different administrative areas of the country will be known. The Directors of clinics in these areas could easily supply to the Medical Officer of Mental Health a list of practitioners who have referred patients to their clinics; and this officer could prepare a consolidated list and compare it with the list of doctors practising in the area.

While it should be left to the Directors of Psychiatric Units and of Central Psychiatric Clinics (perhaps in consultation with the regional professor of psychiatry and with the Medical Officer of Mental Health) to devise the case-sheets and the records system that they regard as most appropriate, it is possible that a basic scheme permitting ready co-ordination would be generally acceptable.

In any case, the problems raised in this section should not be left to solve themselves. They require, and will doubtless receive, very careful thought from the Directors of newly established Psychiatric Units and Central Clinics.

2. The Psychiatric Clinic and the General Practitioner.

The relations between the psychiatrist and the general practitioner have not, in the past, been universally harmonious. The psychiatrist has complained that the general practitioner is slow in spotting the case of early psychosis or of treatable neurosis, and that these, if sent to him at all, arrive too late. The general practitioner on his side complains that he gets little assistance from the psychiatrist, who is apt to write unhelpful letters and too often fails to benefit the patient.

I have commented earlier in this report on the fact that the regional investigators of Region II (the West Riding) report that some 15 per cent only of the general practitioners in and around a certain town make use of the psychiatric services provided in that town.

There are good reasons for hoping that the improved education in psychiatry which the Royal College of Physicians has recommended for the medical student of the future will help to bridge this gap. The student will learn much of his psychiatry at a Teaching Psychiatric Unit, where he will become familiar with what the clinic can do for out-patients : an important part of his training will consist of learning how the general practitioner and the psychiatrist can best co-operate with each other.

The patients whom the practitioner sends to the psychiatric clinic fall roughly into three main groups. The first consists of cases showing marked disorders of behaviour and needing immediate disposal. The practitioner is glad to have these patients taken off his hands. The second group comprises those patients as to whom the practitioner needs a specialist's opinion : he wants a diagnosis and is usually glad of some guidance as to the line of treatment he should follow. The third group consists of patients whom he feels need some course of treatment which the clinic can provide but which is outside his personal range or resources. A course of systematic psychotherapy would be included here.

It should be the aim of every psychiatric clinic to establish co-operative relations with as many as possible of the general practitioners working in the area covered by the clinic. Such a liaison can only be attained by the clinic providing the practitioners with a service which they recognize as helpful to themselves and beneficial to their patients. In this connection the patient's first visit to the clinic is of much importance. If this visit is arranged under an appointment system, it shou.d be possible for the psychiatrist to take, over each patient, the time necessary to establish an at least provisional diagnosis and to obtain all the information necessary to make a decision as to disposal. A careful letter, designed to give the maximum help (and, if wanted, guidance) to the practitioner should be written, and time should be allowed for this indispensable step in each doctor-session. The psychiatrist may like to keep an eye on a patient for a limited period and may arrange for a few return visits. But it should be his aim to restore the patient to the practitioner within a certain specified time.

The above remarks will probably appear to most readers so obvious as not to be worth making. They are here included for one reason only—namely, that many clinics easily slip into the habit of accumulating a massive and unwieldy attendance of chronic patients who haunt the out-patient department year in and year out, reporting fluctuations in their condition but making no essential progress. They are frequently sustained by habit and by a superstitious f ith in the quality of the medicine which the hospital provides. Such chronic patients unduly magnify the numbers of return attendances ; and it is frequently found that they have lapsed into this dependency

because a definite line was, for one reason or another, not taken when they first attended the clinic.

It is quite another matter if the patient is receiving a course of systematized psychotherapy from psychiatrists who specially undertake this work. There is much divergence of opinion as to the worthwhileness of different systems of psychotherapy, and the selection of the appropriate patient for such time-consuming treatment is not always easy. Many psychiatrists using short-period psychotherapy like to fix a time-limit for a course of treatment before they start; and they try to carry the patient along in a momentum of improvement wherein stagnation is avoided. Many hold that it is in the general interests of the clinic to get rid of patients before they begin to stagnate. An active confidence in the clinic is best maintained and spread if its patients have a spirit of optimism as to recovery; in this respect, a psychiatric clinic is like a rehabilitation centre, where the prevailing atmosphere is all-important. It is difficult to sustain a spirit of cheerfulness, wherein expectancy of recovery is high, if the out-patients include many chronic cases who say to the newer cases, 'I've been attending here for years and I'm no better.'

It is therefore suggested that when the general level of psychiatric knowledge is raised throughout the medical profession by improved teaching methods—or even before this happy time is reached—it should be the aim of the clinic to send the patient back to his doctor, reporting improvement, at the earliest date reasonable, at the same time furnishing the practitioner with guidance as to how to handle the patient in the future.

In Chapter XVII, paras. 12 and 19 (pp. 153 and 180), tables are given showing, for different classes of clinic, the ratio between total and first attendances. For a clinic which does not particularly undertake systematic psychotherapy, a very high ratio (implying numerous returns to each first attendance) may indicate that the clinic is burdened with many chronic patients. A very low ratio may suggest that the clinic is mainly diagnostic, and undertakes little treatment. What should we regard as an appropriate ratio for a clinic with limited facilities for systematic psychotherapy? Allowing for the fact that in every clinic a considerable proportion of first attendances are not seen again, a ratio of from two to four total attendances to every new patient would seem reasonable. But clinics which undertook much systematic psychotherapy would have higher ratios.

3. Education in Mental Health.

This subject was briefly discussed in Chapter XII as coming within the province of the Medical Officer of Mental Health. It was there mentioned that the rural districts of the country tended to be psychiatrically backward, and that in urbanized districts there was much variation in what was called 'psychiatric awareness'. The public needs to be educated in the elementary principles of child development and mental health, and requires to be introduced to such psychiatric services as are developed in the area.

The voluntary associations comprised in the Provisional National Council for Mental Health have given much thought to this question of education, and have produced some simple leaflets and pamphlets which will be found useful by those undertaking to give lectures or conduct propaganda. The matter has also been taken up by some Medical Superintendents, among them by Dr. Thomas Beaton of St. James's Hospital for Nervous and Mental Diseases, Portsmouth, whose work in this sphere deserves to be widely known by Local Authorities. A feature of the psychiatric service established by Dr. Beaton is the Mental Treatment Department established, in geographical independence of the Mental Hospital, in the centre of the city. This department is equipped with offices for interviews, a general office, waiting-rooms and facilities for a comprehensive system of filing. Here the legal work of the Mental Deficiency Acts is carried out; there is a central bureau of information for the general public; and a close liaison is maintained with the social services and institutions of the city such as the public health and education departments, the magistrates courts, the Public Assistance Committee and organizations concerned with welfare. This central department in fact carried out all the functions which have been proposed in earlier sections of this report as appropriate for the out-patient department of an active psychiatric unit. But Dr. Beaton's Mental Treatment Department has no beds on the spot. He is of the opinion that such beds would be scarcely necessary in Portsmouth because of the negligible dimensions of the prejudices against the city's Mental Hospital. Indeed, the establishment of such beds might be construed as a concession to these prejudices which it has been one of the objects of Dr. Beaton and his predecessor, Dr. Henry Devine, to dissipate.

The enlightened attitude which prevails in Portsmouth has been the result of a well-organized system of propaganda. The following is an extract from a paper which Dr. Beaton recently delivered at a conference called by the Provisional National Council for Mental Health:

'PROPAGANDA AND EDUCATION OF THE PUBLIC.

'An organized social service would remain barren if the public made no use of it, and in the field of nervous and mental disorder there were exceptional difficulties to be overcome, arising out of traditional fears and almost complete ignorance of modern resources. Every effort must be made, therefore, to bring the facts before the public and to educate them away from old superstition and archaic ideas.

'In most towns there are many lay societies which afford platforms from which the public can be reached; and in Portsmouth medical officers and psychiatric social workers of the Mental Treatment Department have given a number of talks to many sections of the community during the past years.

'The Post-War Brotherhood, the Rotary Club, rate-payers' associations, various church and chapel guilds, to instance the type of meeting, have from time to time invited speakers to talk to them. The personal contacts as well as the information supplied have gone a long way to establish confidence and to spread knowledge of what can be done to alleviate nervous and mental distress. After such a talk questions are always

invited and if personal problems are presented patients are advised to go to their own doctors to get a letter of admission to the clinic.

'The principal points which, it was found, needed emphasis were as follows:

1. Insanity is a purely legal term, and no patient need be certified as insane unless the legal situation necessitates such a course.
2. Even if certified as insane, patients can and do recover if they come to hospital soon enough; and no patient can be "put away" indefinitely.
3. That nervous and mental illness is just as amenable to the right treatment as any physical or bodily complaint.
4. That the mental patient is not a freak of nature but has feelings and thoughts, pleasures and pains, just like those of any ordinary person.
5. That every man or woman has suffered from mental symptoms in the course of experience of love, grief, disappointment, etc.
6. That there is no fundamental difference between "nerves" and "mind".
7. That there should be no time lost in seeking treatment if good results are to be obtained.
8. That anyone, rich or poor and whatever his station, can get advice from the clinic or receive treatment in the hospital if he needs it and asks for it.

'Special attention has been given to interesting the members of the medical profession. Fortunately, Portsmouth's local division of the British Medical Association is very active, and by personal contact and occasional lectures much information has been passed along. The recovered patient sent back to see his doctor is a potent argument which the doctor does not fail to appreciate. Local practitioners are invited to visit their patients while under treatment. Special clinical demonstrations, such as one given recently which turned out to be very popular, on the modern electrical consulsant therapy, are very useful.'

The two essential features of the policy described above are, firstly, that Dr. Beaton arranged for his psychiatrists and the members of his accessory services to take part in a campaign of public speaking. Platforms provided by lay societies, church and chapel guilds, etc., were sought out, and a supply of lectures was married to a ready demand. And, secondly, that pains were taken to acquaint general practitioners with recent developments in therapeutics. The success attained by Dr. Beaton in overcoming prejudices about lunacy, etc., was vividly demonstrated to me by the way parents, with an apparently complete absence of misgivings, brought their children by appointment to the Mental Hospital for child guidance.

Mental Health Committees can learn much from the organization set up in Portsmouth and from other comparable organizations. The Medical Officer of Mental Health should have no difficulty in forming a panel of lecturers from psychiatrists, from the personnel of the accessory services and from picked members of the nursing staff in his area; syllabuses could be prepared, along the lines of the one above quoted, of lectures describing how public opinion about mental illness originated, how it has been enlightened in recent years and how it could evolve in the future; and the local services could be described

together with such plans as may have been approved for their future development. Use might well be found for a few short films of an educational character round which these lectures could be built. An enterprising Medical Officer of Mental Health or Superintendent who prepared his own film, showing the local facilities, might well find the effort repaid in dividends of increased understanding and goodwill. But for obvious reasons, care would have to be taken in showing individual cases. There are great educational possibilities in the film; these apply especially to child psychiatry including play therapy, to all methods of testing and to procedures used in vocational guidance and industrial psychology. These could be used to demonstrate the comprehensive character of a good mental health service. The voluntary societies might play a useful part in preparing this and other material with a view to increasing the psychiatric enlightenment and awareness of the public.

4. Changes in the Law : Certification.

The Lunacy Act of 1890 is now more than half a century out of date, and since it was passed important changes have occurred. The Mental Deficiency Act was passed in 1913 and amended in 1927; the Board of Control has been set up and the Ministry of Health established; the poor laws have been altered; education has been reformed; and, by the Mental Treatment Act, 1930, the Voluntary and the Temporary categories of patient have been redefined. To-day still more radical changes are foreshadowed by the provision of a complete medical and rehabilitation service free for everyone. The air would be cleared, procedure would be simplified and a new psychiatric era would be introduced by the passing of a consolidated Mental Health Act, 194 (?), which would embody the essential features of the Lunacy, Mental Deficiency and Mental Treatment Acts, together with such new provisions as are indicated by recent developments of practice and opinion.

The measure would require to be adjusted to changes introduced by the Education Act, 1944, and to impending changes in health services, public assistance and local government. It is probable that many months and perhaps years will elapse before parliamentary time is available for such an enactment. Among the possible reasons for postponement is the well-recognized and regrettable fact that legislation wherein are raised the subjects of mental disorder or defect is always of a difficult and controversial character. The question of the liberty of the subject is involved; and strong sentiments are evoked and expressed in both Houses.

There would be little profit at this stage in trying to envisage the features of a consolidated Mental Health Act. But there is one principle on which a concensus of opinion has been expressed by professional bodies and voluntary associations concerned with psychiatry. It is that the provisions of Section 5 of the Mental Treatment Act be extended to all 'involuntary' patients, who, *on medical recommendations only*, should be admitted to Mental Hospitals and treated for

six months (extensible by another six months if there were a prospect of recovery).

There would, during this time, be no certification and no intervention by a judicial authority.

This expansion of the essential principle of the Mental Treatment Act is advocated because it has been found that an appreciable number of 'involuntary' patients respond quickly to treatment and are discharged cured. Of these it can be said that, in a medical if not in a legal sense, they were 'unnecessarily' certified. The innovation is prompted by a desire to spare as many patients as possible the 'stigma' of certification, and is advocated out of consideration for the feelings of the patient after recovery and of the relatives at all stages. It is designed to circumvent for the individual and his kin an experience which provokes bitterness and shame.

But the measure may well be opposed on the grounds that it places too much power in the hands of doctors. It may be argued that, between doctors, collusion is possible, and that the intervention of the magistrate, who is responsible for the actual process of certification, constitutes a protection to the individual against such collusion. This fear of collusion is recognized by all persons competent to form an opinion to be an anachronism; and there is no doubt that the measure in question would confer upon the individual patient a benefit which would overwhelmingly counterbalance the imaginary risk to his liberty. But opinions on these matters are all too frequently formed on a basis of prejudice rather than of experience; and feelings in either House might well be roused by an eloquent speaker who set out to champion the cause of individual liberty.

It is therefore desirable that safeguards should be carefully thought out, clearly formulated and unanimously advocated by the professional bodies and voluntary organizations which espouse this innovation. The safeguards applicable to the temporary patient are not entirely appropriate to all involuntary patients: they require that he should be seen by at least two members of the Visiting Committee within a month of reception. This period might well be regarded as too long. A minority of persons requiring immediate admission will show refractory paranoid reactions, and resent what they feel to be an outrage. In such cases it might be made obligatory for the Medical Superintendent of the Mental Hospital admitting the patient to arrange for one or more lay members of the Mental Health Committee to see the case forty-eight or seventy-two hours after admission; and for these, the help of the Medical Officer of Mental Health would be available if required. But this is a tentative suggestion only, and better arrangements could probably be devised.

The point is that this matter should receive careful consideration and that an agreed policy be formulated. It would help much if figures could be produced showing how many patients might have been saved from certification in a given year if such a measure had been in operation. How many patients, who are now by legal necessity certified, recover within six months or a year and are discharged cured? Figures should be easy to collect and to make known. If the education

of the public in matters of mental health by the Medical Officer of Mental Health and others were undertaken along the lines suggested in an earlier part of this chapter, this humane reform might well be included among the subjects brought forward. Indeed, it may turn out that a delay in the consideration by Parliament of a consolidated Mental Health Act might have advantages if it enabled the competent authorities and organizations concerned to make up their minds on exactly what innovations they wanted and on what safeguards they proposed.

5. Regional Disparities and Minimum Standards : Voluntary Effort and Planning.

In this report I have made various suggestions as to how the psychiatric services of the country might be co-ordinated so that minimum standards be attained. These suggestions raise important issues, now much in the forefront of discussion, which seem to me to belong to the sphere of what might almost be called social philosophy. In this, the final section of Part II of my report, I should like to be allowed briefly to discuss these issues as I see them. The section could, indeed, be regarded as a postscript to the report as a whole, written from a more personal standpoint than the rest.

The publication of the White Paper on the Health Services has given rise to vigorous controversies which, in any but a totalitarian state, should be looked upon as a healthy sign. The psychiatric services form part of a large whole—the health services; and suggestions as to how the former might be co-ordinated will doubtless raise discussions similar to those which have been evoked by the larger issues. Let us therefore first consider the steps by which, in the sphere of psychiatry, the present position has been reached.

The origins, history, objects and scope of the neurosis survey were discussed in the first chapter of this report. The fact was there brought out that the demand for a survey arose from dislocations in the psychiatric services caused by the war. But there are reasons for thinking that the war served but to accelerate sequences which, given time, would have revealed themselves in the absence of war. What are these sequences ?

The problems of mental disorder and defect have always been with us. But it was in the last half of the nineteenth century that the administrative problems which they presented, and the need for the reform of laws and institutions, were mainly recognized. Archaic ideas as to the causation of mental disabilities still widely prevailed, and the arguments for change were obvious. The Lunacy Act of 1890, now over half a century out of date, was an important landmark.

In the next two decades—from 1890 to 1910—it was increasingly recognized that the sphere of mental disorders was wider than that of lunacy and defect. The work of the Salpetrière, which played a part in the birth of the psycho-analytic movement, and a general interest in the therapeutic possibilities of hypnosis contributed to this wider

conception. It was in this period that the first psychiatric departments of hospitals were established in this country.

In the following twenty years—from 1910 to 1930—the medical and social importance of neurosis was widely recognized. The Great War of 1914–18 played an important part. The abreactive treatment of what was then called shell-shock gave extensive though perhaps misleading publicity to the principles of psycho-analysis, the importance of which had previously been recognized by but few British psychiatrists; intense interest, extending far outside medical spheres, was focused on problems of neurosis; and the possibilities of early and preventive treatment were increasingly perceived. Psychiatric departments continued to be established—most of them offshoots of departments of neurology—in big Voluntary Hospitals; numerous voluntary associations concerned with psychiatric problems were established; the Maudsley Hospital was founded; and a Royal Commission on Lunacy (1926) prepared the ground for the Mental Treatment Act of 1930. This Act laid the foundations of the extra-mural psychiatric services which exist to-day. The Mental Treatment Act, which initiated a new period, in effect empowered Local Authorities to make provision for the treatment of neuroses and the early treatment of psychoses; and the basis was laid for a statutory service which grew up alongside of the pre-existing service furnished by the country's Voluntary Hospitals.

But the Mental Treatment Act gave to Local Authorities *powers* to establish clinics; it enjoined no *obligations*; and it inevitably happened that the powers were used unequally.

The Second World War, wherein the importance of psychiatric causes of invalidism in the Fighting Services was recognized from the first, dislocated and depleted the available personnel, thus magnifying the inequalities; and at the end of 1942, the publication of the Beveridge Report, whose Assumption B called for comprehensive and free medical services, further drew attention to these aggravated regional disparities. It has been the acceptance by Parliament of the far-reaching principle of a free health service which has transformed the situation. A free service calls for the definition and general adoption of minimum standards common to all areas wherein the free service is effective. But it is next to impossible to define a practicable minimum standard without first assessing what are, in fact, the prevailing standards.

The principle of a free and comprehensive health service, accepted by Parliament after the neurosis survey had begun, thus created a second need for information greater even than the one from which the survey had originated. The war thus provided a double cause and justification of the survey—both by dislocating the existing services and, less directly, by generating the conditions which gave rise to the recommendations of the Beveridge Report.

Before the war, the growth of extra-institutional psychiatric services had been largely spontaneous. Until 1930 this growth was mainly influenced by a growing enlightenment within the medical profession as to the nature and scope of neurosis. These broadening

views had reflected themselves in the development of psychiatric departments of hospitals; in the establishment under the London County Council of the Maudsley Hospital; and in the growth of influential voluntary organizations such as the Tavistock Clinic, the Central Association for Mental Welfare, the National Council for Mental Hygiene and other bodies including those concerned with the analytic movement. The Royal Commission on Lunacy was assisted by these agencies in moulding public opinion for the acceptance of the Mental Treatment Act, which gave Local Authorities powers, but imposed few obligations. These growths were vigorous but spontaneous; they tended to centre in and radiate from London; and they left wide scope for the development of regional disparities. Upon this process of spontaneous and autonomous growth the demand for a minimum standard comes with what may seem to be disruptive effect. The definition and establishment of such a standard calls for some central plan; and the planner is confronted with the task of adjusting his plan to the many organizations—rich in valuable traditions and equipped with important experience—which have laid the foundations of the existing services.

A danger is disclosed of a totalitarian medicine and, as part of this, of a totalitarian psychiatry. The word 'planning' comes into disrepute, the planner being visualized as a bureaucrat who aspires to directing, from some central vantage-point and in accordance with a rigid formula, the development of all services. He is seen as the enemy of spontaneous growth and of voluntary institutions, a promulgator of regulations and a manipulator of red-tape. And the paradoxical situation develops that everyone becomes in some degree a planner. The professional organizations, the voluntary associations, the various political parties appoint planning committees from which there flows a plethora of plans.

These diverse activities and the controversies to which they give rise are a healthy and encouraging sign. For they amount in the end to no more than that everyone is trying to think ahead and to define his ideas as to how the principles and practices which he values can best be retained in the new dispensation. Such multifarious energies might be described as peripheral planning; and no reasonable person will discount their value. But we may further distinguish two kinds of central planning. The first, which might be described as authoritarian planning, is of the kind which has brought the word into some disrepute. It is typified by the institutions of the countries with which we are at war, wherein unlimited powers are vested in central directives and where the persons wielding influence are mostly servants of the state. The term 'state medicine' is used by many doctors in derogation of a system wherein they see themselves converted into functionaries or else transformed into servants of the state or of Local Authorities.

But there is a second type of central planning which might be described as the product of evolutionary liberalism. The object of such a liberal planning is to create the legal and administrative framework which will give maximum scope for spontaneous and autonomous

growth. In the measure that social organizations and patterns alter, so must this framework be susceptible of evolutionary change. The controls and central directives in such a system should be reduced to the smallest dimensions necessary to prevent abuses and the growth of inefficiency, and to adjust minimum standards to changing social patterns. A system of liberal planning encourages the decentralization of authority and seeks to promote local initiative and autonomy to the maximum degree compatible with efficiency and with the observance of agreed minimum standards. It encourages local traditions and experiment, and favours diversification in the context of local circumstances, sentiments and needs. The second type of planning is much more difficult to carry out than the first; for it demands neither intelligence nor knowledge to make a clean sweep of existing traditions and institutions and to replace them by a series of arbitrary regulations devised by a central authority. Indeed, the position is comparable to that which confronts the educationist. It is much easier to bring up a child, whether in the family circle or else in an institution, in accordance with a system of rigid rules and regulations than it is to develop to the utmost the child's native capacity for independence and initiative. The second method calls for a sympathetic study of the qualities of each separate child and a capacity to adjust a small number of unrestrictive rules to the processes of growth. The first calls for nothing but complacency and an autocratic habit of mind.

The second is the kind of planning which I have sought to realize in the foregoing suggestions and proposals. I have taken pains to keep myself informed of the plans relating to the medical and psychiatric services which have been drawn up by the many professional organizations and voluntary societies concerned with psychiatry; and on many points I have sought, and taken, guidance from these. At the time of writing, I am in a better position than most to make suggestions as to future developments because I have to hand the results of the neurosis survey. But this privileged position will be terminated by the publication of the survey's findings, when the findings themselves and the suggestions based thereon, will doubtless be subjected to critical discussion. The proposals contained in previous chapters, in so far as they can be called a 'plan', will be available, not for authoritarian central implementation, but as a basis of general discussion. In the light of financial considerations, they will have to be adjusted to other 'plans' produced by other medical specialties, none of which can claim priority when it comes to spending public money. This adjustment is a necessary task of a central authority.

A final word about voluntary organization and effort. To these the psychiatric services of the future, if organized in a liberal rather than an authoritarian spirit, should give every encouragement. Upon this topic the Feversham Committee, which was mainly concerned with the co-ordination of the efforts of certain voluntary associations concerned with mental health, made noteworthy comments. Voluntary organizations, they point out, are in a better position than is the statutory authority for testing new ideas and for promoting new

experiments. They provide the advance guards which may either founder on difficult obstacles or clear the way along which the main body can safely follow. Compared to the cautious movements of the statutory body, the voluntary organization is independent and untrammelled; and it provides a stimulus to thought and action.

It is admittedly open to anybody to found a voluntary organization designed to further almost any aim; and many include among their members cranks and misguided enthusiasts. Voluntary societies and associations are subject to a process of natural selection and to a struggle for existence wherein many miscarry, languish and die a natural death. But a few, especially those led by reasonable and capable people, survive to produce valuable and lasting results. Many beneficent and progressive movements have begun through voluntary effort; many voluntary bodies have influenced legislation, and the functions of some have been taken over by statutory authority. Voluntary associations and movements are a feature of a free and healthy democracy and of a liberal society; they are the negation of totalitarianism.

Voluntary organizations are apt to espouse the cause of the individual and to ignore social precedents reached in an effort to reconcile the conflicting claims of individuals and established in the general interests. Hence they are apt, in the early stages of their development, to clash with statutory authorities which have administrative responsibilities. Thus penal and lunacy reformers and advocates of the analytic treatment of delinquency champion the cause of the individual; but persons charged with administrative responsibilities are compelled to think in terms of the precedents which may be set by these humanitarian innovations. The Industrial Medical Officer may receive from a worker's private doctor a recommendation that the worker's job be changed because of some minor psychiatric illness: the Industrial Medical Officer might be glad enough to recommend the change, but hesitates because of what he pictures might happen if it got about that anyone could get his job changed if he complained of certain emotional symptoms. Prison and Industrial Medical Officers have to think of the social effects of measures recommended in the interests of the individual: they are concerned with precedents and the danger of abuses. But if the statutory officer is humane and progressive and if the voluntary organization is sensible, common ground is reached to everyone's advantage. In a long view, it is a good thing that the cause of the individual should be espoused, even if some of its advocates are irresponsible or silly. With changing social patterns and standards, the status of the individual alters. Pressure is needed to prevent laws, regulations and conventions becoming rigid.

In the sphere of psychiatry, the voluntary organization has been of indisputable value. The associations now combined in the Provisional National Council for Mental Health, the Tavistock Clinic, the British Institute of Psycho-analysis, the Mental After-Care Association and other bodies, have accomplished tasks which could hardly have been undertaken by an official or statutory body. It is desirable that, in the future organization of the psychiatric services, such voluntary

associations should not only be permitted, but should be actively encouraged, to continue their activities. They might with advantage be allowed representation on central organizations, whether professional or, in an official sense, advisory; and much can be said for further developing the practice of giving financial help from central funds to deserving and useful voluntary bodies.

PART THREE

POST-WAR PSYCHIATRIC SERVICES: SHORT-TERM RECOMMENDATIONS

CHAPTER XVI

THE POST-WAR TRANSITIONAL PERIOD

In Part II of this report an attempt has been made to review the needs, and to outline a possible structure, of the post-war psychiatric services of this country. Various long-term considerations and suggestions were put forward.

In Chapter VI it was suggested that, to produce better psychiatric services, four needs required to be met in the following order of priority: good psychiatrists in sufficient numbers; good all-round training for psychiatrists and mental nurses; adequate accessory services; and, lastly, good buildings and material facilities. First priority is given to the recruitment, selection and training of the essential personnel. It was further remarked that good psychiatrists cannot be produced at a moment's notice. Men and women who will have benefited from the training provided by the revised psychiatric curriculum now under discussion will not be entering the field for another five years. Interim arrangements, especially affecting post-graduate training, will be called for during the difficult 'transitional' period which will follow the beginnings of peace and of demobilization. Other specialities are in the same predicament. The comprehensive and free services which have been promised call for an appropriate distribution of specialists and consultants in areas where these are now too few. The main problem everywhere is a shortage of adequate personnel. This difficulty cannot be remedied overnight. It will take one or even two five-year plans to establish a comprehensive mental health service on a permanent footing.

The 'transitional' period which must intervene will have distinctive features which derive from the war and its aftermath. What, from the psychiatric standpoint, will be the needs of this period? These can be briefly dealt with because the essential ground has already been covered.

1. Needs of 'Transitional' Period.

Among these needs will be the following:

(1) That means be found for dealing with the awkward *current problems* of the period, which may suddenly become clamorous. The discharge from the Forces of neurotic and psychopathic men has been proceeding continuously since the war began. We do not yet know what measure of demobilization will be

possible when the European war ends and the scene changes to the Far East. It is possible that the Services may be combed and that the discharge of mentally infirm persons will be accelerated. Many normal men demobilized from the Forces and repatriated from prison camps will have difficult problems of adjustment. When tensions relax and the pressure on industry is reduced, there may be a reaction after the first wave of jubilation has passed. In the last four years the civilian population of the country has undergone unprecedented strains. Many have suffered from air raids; evacuation has caused stresses, especially for children; the housing shortage, which is among the consequences of the air raids, has caused hardships; conscription, involving compulsory transference of personnel from one part of the country to another, has been a difficult experience, especially for young girls; the long hours and other current stresses of work in war-time have not been without effects. Anyone with psychiatric experience of the years 1920–39 will recall with what frequency neurotic disabilities were attributed (often wrongly) to experiences of the last war. Few can doubt that the same thing will recur, and that the volume will be greater than last time in the measure that this war has been longer and its tribulations more severe. Latent neurosis, which is believed by many to exist, may reveal itself either overtly by increased attendances at psychiatric clinics, or indirectly by an augmentation of the number of psychosomatic illnesses seen by practitioners and treated in the non-psychiatric wards of hospitals.

(2) That full use be made of, and fair treatment accorded to psychiatrists demobilized from the Forces.

(3) That facilities be established for equipping psychiatrists so demobilized, and also such psychiatrists working in Mental Hospitals and the E.M.S. as may feel themselves concerned, for the extra-mural duties which are likely to be increasingly undertaken in the future.

(4) That steps be taken to bring the position of the mental nurse into closer alignment with that of the generally trained nurse.

(5) That attention be given to the needs of children, *i.e.* to the earliest detection within the education services of sub- or abnormalities, and to the provision of adequate means of community care and of appropriately distributed Child Guidance and Child Psychiatric services.

(6) That facilities be established for training accessory services, especially psychiatric social workers, psychologists and occupational therapists, in adequate numbers.

(7) That in implementing the above measures, the foundations be at the same time laid for such 'long-term' organization of the psychiatric services as is eventually approved.

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2. Interim Post-Graduate Psychiatric Teaching Centres.

In building up a comprehensive psychiatric service, two courses present themselves. We could either refrain from making any change until we had adequate numbers of completely trained all-round psychiatrists available—which would mean postponing effective action on behalf of the public for several years; or we could make the most of psychiatrists now available, and likely to be available as demobilization proceeds, by giving them the best possible *ad hoc* training for the new work. Few can doubt that the latter course is preferable, though it is exposed to the criticism that we are creating half-baked or three-quarters baked specialists. Our psychiatric resources may be fully stretched during the period which will intervene between the first mitigation of hostilities and the final attainment of peace.

During the transitional period, the problem will be one of post-graduate rather than of undergraduate training. I suggest that there be established a small number of *interim post-graduate psychiatric teaching centres* designed to complete, in a period of about six months, the all-round equipment of psychiatrists so that they can undertake, in addition to the routine duties of a Mental Hospital or Certified Institution, all branches of outside work. Psychoses and mental deficiency will claim as much attention as heretofore, though the emphasis may be different; but in addition the psychiatrist will be called upon to deal on a wider scale than formerly with neuroses, child guidance, juvenile delinquency, criminal and industrial psychiatry. Few present-day psychiatrists have this all-round equipment. Those whose main experience is of institutional work will have the necessary competence in psychoses and mental deficiency; but they may feel that they have something to learn about the proposed extra-mural activities. Those who began their psychiatric careers in the Fighting Services during the war will have seen much of neurosis and minor degrees of dullness and defect; but they will have had few contacts with children, chronic psychotics and low-grade defectives. And they may want to know more about recent developments such as convulsant therapy and pre-frontal leucotomy. The fact is that the majority of psychiatrists, wherever they are placed, will have adequate experience and competence in some fields, but not in all.

The object of the interim post-graduate psychiatric teaching centre would be to fill these gaps. The need for post-graduate study is likely to be greatest in child psychiatry. If Child Psychiatric Clinics and Child Guidance Centres are set up along the lines that have been suggested in this report, there will be a demand for a much larger supply of child psychiatrists than is at present available. Every effort should be made to instate, in the interim teaching centres, child psychiatrists who, as teachers, could give the best possible grounding in this important subject. Appropriate lectures and demonstrations on other subjects such as industrial medicine and criminal psychiatry would need to be carefully organized.

If, as part of a long-term policy, it is decided to form Teaching

Psychiatric Units as constituent parts of university medical schools, it would be a good thing to pave the way by establishing interim teaching centres in connection with these medical schools. The machinery set up for post-graduate teaching could later be adapted to the needs of undergraduates ; valuable teaching experience would have been gained ; and the *practical* orientation set by post-graduate work would be a useful asset.

Where should these interim centres be located ? Obviously one should be established in London, and the Maudsley Hospital suggests itself as a suitable place. It has excellent out- and in-patient accommodation ; it is actively concerned with child psychiatry, and has been little damaged by air attack. But full use should be made of London's other facilities. Guy's Hospital has an active Teaching Unit, well equipped with beds since the York Clinic was opened in 1944. The Tavistock Clinic has been successful with post-graduate teaching. Analytic principles have immensely influenced psychotherapy ; the Institute of Psycho-analysis might devise a useful programme of lectures for graduates, most of whom would not become qualified analysts. Another interim centre might be established in Bristol, which is well equipped from the standpoint of teaching staff. Liverpool would be geographically convenient and would cover some of Wales. Birmingham is also well placed, and could provide first-class teaching in child psychiatry. And a centre in Edinburgh or Glasgow would be needed in Scotland. But decisions on this matter would primarily rest with the universities and medical schools concerned, though some co-ordination might be required.

The curricula organized by the post-graduate centres should as far as possible be based on a common pattern, though variations depending on local conditions and teaching facilities are desirable. I recommend that steps be taken forthwith to prepare such a basic syllabus for the consideration of the authorities of universities. This syllabus would require to be drawn up centrally in consultation with the individuals and organizations concerned with child psychiatry, juvenile delinquency, criminal psychiatry and industrial medicine. The committee appointed for this purpose should include a representative of the London School of Hygiene and Tropical Medicine.

3. Candidates for Post-Graduate Training.

The number and location of interim post-graduate teaching centres would depend much on the demand arising from graduates for the training which these centres could provide. The main sources would be psychiatrists now working in Mental Hospitals and E.M.S. who might want further experience in extra-mural duties; and psychiatrists now in the Forces. I see no reason why an estimate should not be formed of the demand in these two groups. The Visiting and other relevant committees of Local Authorities doubtless realize that they may be expected shortly to strengthen their out-patient activities, particularly in respect of child psychiatry, but also in other directions. They might be informed of the projected establishment of post-graduate

teaching facilities and of the ground which would be covered. They might be asked to discuss the matter with the Superintendents and other medical staff concerned, and send in an estimate of the numbers who might avail themselves of the facilities.

A similar course might be taken with psychiatrists now in the Forces. Many of these have assured prospects on demobilization, having joined the Services from a post in a Mental Hospital, to which they intend to return; but others have taken up psychiatry after putting on uniform, and have no clear ideas as to their future; yet others have left positions which promised well at the time, but which would be difficult to re-establish. Facilities for making a satisfactory adjustment to professional work in civil life should be afforded to every Service psychiatrist; and everything possible should be done to allay the unavoidable mistrusts which are felt by men in the Forces about the prospects which confront them on returning to civil life. It would be a good thing if an opportunity could be offered to every Service psychiatrist to attend, after demobilization, a four to six months' course at a post-graduate teaching centre, at full pay according to the rank held on completion of service, without prejudice to the period of leave to which he is entitled on demobilization. It might also be possible to arrange that if, on demobilization, Service psychiatrists joined the mental health service, their seniority would date from the day on which they assumed specialist rank. But these proposals would need to be co-ordinated with the conditions offered to doctors in the Forces as a whole when they are demobilized. It would be unfair to offer better terms as to post-graduate and refresher courses to one specialty than another, though some elasticity should be admissible between specialties if some have made further advances during the war than others.

I suggest that no time need be lost in sending to psychiatrists in the Forces an outline of the facilities for post-graduate training which it is proposed to offer them. They might be asked if, to help in the planning of the courses at post-graduate centres, they could give some indication of whether, on demobilization, they would want to avail themselves of the proposed facilities. They need not commit themselves by an affirmative or negative answer, but their replies would provide some sort of guide. A similar inquiry might be directed to non-medical psychologists in the Forces if it were decided to offer them analogous facilities on demobilization.

4. Accessory Services.

These are essential features of a mental health service. In Chapter XIII it was pointed out that existing training facilities for psychiatric social workers, psychologists and occupational therapists cannot in the near future meet present demands; and that, in two of these services (psychologists and occupational therapists), bottle-necks exist. It was further suggested that the demand for trained workers in these two services, the demand of candidates for training, and the available training facilities be officially investigated in relation to each

other. There is every reason why such an investigation should be set on foot without delay.

5. Establishment of Further Psychiatric Out-Patient Clinics.

It has been noted in earlier sections of this report that, of 216 psychiatric clinics covered by the survey, 150 were staffed by psychiatrists from Mental Hospitals. The position is shown in the following table :

TABLE I.—*Psychiatric Out-patient Clinics established by Mental Hospitals in England and Wales. Eleven Civil Defence Regions.*

Mental Hospitals which have established clinics, as follows :	Eleven Civil Defence Regions.										Total Hospitals.	Total Clinics.
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XII.	
Five . .	..	..	..	..	..	1	..	2	..	..	..	3	15
Four . .	..	3	..	1	..	..	..	..	..	2	2	8	32
Three . .	1	1	1	..	1	3	..	1	2	..	..	10	30
Two . .	1	..	4	1	1	..	3	..	2	3	3	18	36
One . .	4	3	3	6	4	2	4	3	5	2	1	37	37
None . .	..	1	1	2	12	2	2	2	1	1	1	25	0
Totals .	6	8	9	10	18	8	9	8	10	8	7	101	150

It will be seen that, of a total of 101 Mental Hospitals, 76 have established one or more psychiatric clinics, and that 25 have not established a clinic. Of these 25 hospitals, 12 are situated in the London Region. It is a good thing for a Mental Hospital to have an out-patient clinic for at least two reasons. One is that the clinic supplies the public with a useful service ; the other is that it provides interesting work for the staff, and takes them outside the hospital's walls. It would be desirable for as many as possible of these 25 hospitals to open out-patient clinics.

6. Central Co-ordination of Records.

In Chapter XV (pp. 109–113) were considered various systems of record-keeping. Different systems are appropriate for clinics of different complexity.

Co-ordination from some central source is needed to make these records comparable and, when assembled, susceptible of analysis. A system of central co-ordination should be devised as soon as possible.

A summary of recommendations submitted in Part III will be found on page xx.

PART FOUR

MAIN FINDINGS OF THE SURVEY

CHAPTER XVII

DESCRIPTION OF FINDINGS [1]

THE full results of the survey have been set out in some forty-five tables, most of which are elaborate and complicated since they show separately the findings in the eleven civil defence regions. In order to save paper and printing costs it has been decided not to publish these large tables. Copies can be seen by authorized persons at the Ministry of Health. There follows an account of the main findings, accompanied by condensed tables prepared along the lines described on page 5.

1. The Eleven Civil Defence Regions : Their Boundaries, Populations and Investigators.

As remarked above, the survey as a whole is a compilation of the findings of eleven separate surveys, each carried out by three regional investigators in each of the eleven civil defence regions into which England and Wales has been divided. These regions are numbered I to XII ; number XI, which comprises Scotland, was omitted. (Scotland has been separately surveyed and reported on.) In Appendix II are set out the counties and administrative areas comprised in these regions. All are fairly straightforward except Region V, which comprises the London area—Middlesex and parts of the counties contiguous thereto.

Appendix III gives the populations of the eleven regions. The exigencies of war, which include the mobilization of the armed forces, evacuation from large cities and the transfer of labour from one part of the country to another, have produced changes in the distribution of the population whereof the Registrar-General's pre-war figures took no account. The difficulty has been met by calculating the averages of population for the aggregated years 1938, 1940, 1941 and 1942 which are covered by the survey. The constituent figures for 1940, 1941 and 1942 do not include the armed forces. The averages for the four years are shown, in respect of each of the eleven civil defence regions, for their County Boroughs, and also for their Administrative Counties—*i.e.* their Municipal Boroughs, Urban and Rural Districts. Aggregated figures for the whole country are also shown.

[1] The contents of this chapter will be better understood by the reader if he has first considered the introductory remarks on pages 4–8.

In Appendix IV are given the names of the regional investigators. It will be seen that, in each of the eleven regions, there was appointed a representative of the E.M.S., of the Board of Control and of the Army. The representatives of the Army were in several regions changed in the course of the survey. In some regions they were changed more than once.

2. How the Questionnaire was filled in.

Table I (*a*) summarises the results.

TABLE I (*a*).—*Psychiatric Clinics distributed to show how Questionnaire was filled in : (A) C.B.s outside London Region ; (B) Administrative Counties outside London ; (C) London Region.*

Clinics whereby Questionnaire was :	Type of Clinic.			Total.	
	A.	B.	C.	No.	Per Cent.
Filled in in all parts asked for	59	52	34	145	67·1
Incompletely filled in .	22	18	1	41	19·0
Not returned . . .	16	7	7	30	13·9
Totals .	97	77	42	216	100·0

(i) The distribution of the two types of clinics, 'A' and 'B', classified by degree of completeness of the questionnaires, is not dissimilar. London ('C' type) clinics do not fit well into this table because they were not asked to fill in the whole questionnaire ; not many London clinics filled in incompletely the few questions with which they were asked to deal. The three groups of clinics, which are discussed in later tables, are generally comparable.

(ii) Clinics in different regions co-operated with varying degrees of thoroughness. The range was from Region VIII (Wales), wherein all 16 clinics filled in all four parts of the questionnaire and answered every question, to Region II, where only 6 out of 22 clinics filled in all four parts. Regions VI, VII and X gave satisfactory returns, as did the London Region in view of its special difficulties and large numbers.

(iii) Thus psychiatric clinics, on the whole and in view of war-time difficulties, co-operated satisfactorily in the survey. Of 216 psychiatric clinics, 86·1 per cent responded to the questionnaire and 67·1 per cent filled in all the parts asked for.

3. Psychiatric Clinics and Population.

TABLE II.—*Population and Psychiatric Clinics in (A) C.B.s outside London; (B) Administrative Counties outside London; and (C) London Region showing Numbers and Percentages, and Clinics per Million Population.*

Administrative Area.	Population.[1]		Psychiatric Clinics.		Clinics per Million.
	No.	Per Cent.	No.	Per Cent.	
(A) C.B.s outside London	11,963,921	30·2	97	44·9	8·11
(B) A.C.s outside London	20,381,714	51·5	77	35·6	3·78
(C) London Region (V)	7,232,611	18·3	42	19·5	5·81
Totals	39,578,246	100·0	216	100·0	5·47

[1] The population figures are averages of the years 1938, 1940, 1941 and 1942.

(i) In the eleven regions there is a high correlation (r.=·83±·10) between the proportion of the population residing in County Boroughs and the proportion which large-town type 'A' clinics form of the total clinics in the region; the greater the concentration of population, the higher the proportion of type 'A' clinics. This is in accordance with expectation. Comparison of the figures for separate regions, not shown in the above table, shows that in only two did the region's percentage of population living in C.B.s exceed the region's percentage of clinics located in those Boroughs—namely, Regions VI and VIII. In these regions, out-patient psychiatric services have been more generously supplied to the smaller centres of population than elsewhere.

(ii) The eleven regions vary much in the number of psychiatric clinics per million of population. The average for the country as a whole is, as shown above, 5·47 per million, but the figures range between 3·66 for Region X and 9·14 for Region XII. The south of England is much better served than the north: the aggregate figure for the two regions in the north (Regions I and X) is 3·74; the corresponding figure for the three regions which form the south coast (VI, VII and XII) is 7·75.

4. Status and Staffing Arrangements of Psychiatric Clinics.

(i) The questionnaire inquired as to the status of the hospital or other organization which comprised the psychiatric clinic; it also asked how the clinic was staffed. Two salient facts emerged: the big

part which the Voluntary Hospitals play in accommodating psychiatric clinics, and the important rôle played by psychiatrists based on Mental Hospitals in staffing them.

The position is shown in the following tables :

TABLE III.—*Psychiatric Clinics distributed in accordance with their situation in (A) C.B.s outside London Region ; (B) Administrative Counties outside London Region ; and (C) the London Region ; and in Accordance with the Status of the Hospital or Other Organization comprising the Clinic.*

Status.	Administrative Area.				
	A.	B.	C.	Total.	Per Cent.
Voluntary Hospitals . .	72	51	26	149	71·0
Municipal General Hospitals .	8	11	11[1]	30	14·3
Mental Hospitals . . .	6	9	0	15	7·1
Miscellaneous . . .	5	6	5	16	7·6
Totals .	91	77	42	210	100·0

[1] The Maudsley Hospital is counted in this group.

TABLE IV.—*Psychiatric Clinics located in Voluntary and Municipal Hospitals distributed as in Table III and in Accordance with whether they were staffed by Psychiatrists based on Mental Hospitals ('M' Clinics) or otherwise staffed ('O' Clinics).*

Status and Staffing Arrangements.	Administrative Area.				
	A.	B.	C.	Total.	Per Cent.
Voluntary Hospitals 'M' . .	51	42	4	97	54·2
„ „ 'O' . .	21	9	22	52	29·0
Municipal General Hospitals 'M' .	6	11	7	24	13·4
„ „ 'O' .	2	0	4[1]	6	3·4
Totals .	80	62	37	179	100·0

Totals 'M' clinics = 121 (67·6 per cent).
„ 'O' „ = 58 (32·4 per cent).

[1] The Maudsley Hospital is counted in this group.

(ii) It will be seen (Table III) that information as to status and staffing arrangements was available for 210 out of a total of 216 clinics.

In respect of status, the hospitals or other organizations comprising the psychiatric clinic have been grouped in the four categories shown in Table III—namely, Voluntary Hospitals, Municipal Hospitals, Mental Hospitals and a miscellaneous group comprising special E.M.S. hospitals and organizations other than hospitals. Examples of the latter are the important Tavistock Clinic and Institute for Psychoanalysis in London. In small centres of population, the staff of a Mental Hospital may hold sessions in some place other than a hospital: thus, in the Isle of Wight, Dr. C. Davies Jones held sessions at different points in the island, among them at the County Hall in Newport and the Nurses' Institute in Freshwater.

Table III also shows that 15 clinics are established within the curtilage of Mental Hospitals.

In respect of staffing arrangements, we may distinguish between psychiatric clinics staffed by psychiatrists based on Mental Hospitals and those otherwise staffed. Section 6 (3) (*a*) of the Mental Treatment Act, 1930, empowers Local Authorities 'to make arrangements, whether by the provision of institutions or otherwise, for treatment as out-patients, either gratuitously or on such terms as to payment as they think fit, of persons suffering from mental illness'.

That many Local Authorities availed themselves of this power is shown in the next paragraph (5) which deals with the dates of establishment of psychiatric clinics. The procedure adopted in a large number of cases was that Local Authorities made arrangements by which psychiatrists based on Mental Hospitals held sessions in Voluntary Hospitals placed in appropriate centres of population.

(iii) Table III shows that 149 of the 210 'known' clinics were located in Voluntary Hospitals; and Table IV shows that, of the 179 psychiatric clinics located in Voluntary and Municipal Hospitals, no less than 121 were staffed by psychiatrists based on Mental Hospitals; and that of these 121 clinics, 97 were placed in Voluntary Hospitals. The last figure provides an important example, hitherto little recognized, of the participation of the Voluntary Hospitals in the medical activities undertaken by Local Authorities.

(iv) Table III shows that, for all areas combined, 71·0 per cent of the 210 known clinics were conducted in the premises of Voluntary, 14·3 per cent of Municipal, 7·1 per cent of Mental Hospitals, the remaining 7·6 per cent being of the miscellaneous type. This distribution was not the same for each type of area as seen from the figure given by X2; for a higher proportion of clinics in Municipal General Hospitals and of 'miscellaneous' clinics is apparent in the London area. In London, too, there were no clinics situated in Mental Hospitals. Clinics so located were mostly found in the provincial urban districts ('B' type).

5. Dates of Establishment of Psychiatric Clinics.

(i) Reference was made in the preceding paragraph to how the passing of the Mental Treatment Act in 1930 had stimulated the

establishment of psychiatric clinics. The significance of this event may be seen from the following table :

TABLE V.—*Dates of Establishment of Psychiatric Clinics, before and after* 1929, *in* (*A*) *C.B.s outside London ;* (*B*) *Administrative Counties outside London ; and* (*C*) *the London Region.*

Psychiatric Clinics Established :—	Administrative Area.							
	A.		B.		C.		Total.	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
In 1929 and before .	14	17·2	6	9·2	9	29·3	29	16·9
After 1929 . .	67	82·8	59	90·8	22	70·7	148	83·1
Totals .	81	100·0	65	100·0	31	100·0	177	100·0

(ii) Relevant information is available as to 177 out of 216 clinics, of which as many as 148 (83·1 per cent) were established after 1929. Judged therefore in terms of numbers of clinics, the development of the psychiatric services of this country has been very recent and very rapid. Even in the unlikely event that *all* the 39 clinics, where the information was not given, were established before 1930, the percentage founded after the Act has been passed would only be lowered from 83·1 to 69 per cent.

(iii) Of the 177 known clinics, there were none at all before 1930, in Regions I and IV ; there was 1 clinic only in each of Regions III, VIII and IX ; and there were 2 clinics only in each of Regions II and X. Before 1910 there were but 5 known clinics in the country, and before 1919, seven.

6. Activity of Psychiatric Clinics.

The activity of a psychiatric clinic can be estimated in various ways. The following indices are used in this report ;

(i) Frequency with which sessions are held (Table VI).
(ii) Numbers of doctors per session (Table VII).
(iii) Average number of doctor-sessions per week (Table VIII).
(iv) Doctor-sessions per million of population (Tables IX and X).
(v) Numbers of new patients per year.
(vi) Numbers of new patients per clinic-session.
(vii) Numbers of new patients per doctor-session.
(viii) A comparison of the numbers of first and total attendances.

Indices (v) to (viii) are discussed in connection with Tables XV–XX.

(i) FREQUENCY OF SESSIONS.

Psychiatric clinics have been classified in terms of the frequency with which they held sessions. In a few cases the frequency varied throughout the period; that which obtained for the longest period of time has been counted.

Clinics have been divided into those which held sessions relatively infrequently (weekly or less often) and those which held sessions relatively frequently (more often than weekly). The relevant information is available for 192 clinics.

TABLE VI.—*Clinics distributed by Frequency of Session in (A) C.B.s outside London; (B) in Administrative Counties outside London; and (C) in the London Region.*

Frequency of Sessions.	Administrative Area.							
	A.		B.		C.		Total.	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Weekly or less often	58	71·6[1]	63	90·0[1]	20	48·8	141	73·4
More often than weekly . .	23	28·4	7	10·0	21	51·2	51	26·6
Totals .	81	100·0	70	100·0	41	100·0	192	100·0

[1] Difference = 18·4 ± 4·65.

It will be seen that, judged by the standard of frequency of session, large-town or 'A' type clinics are more active than small-town 'B' type clinics; of the former about 7 out of 10, of the latter 9 out of 10, hold relatively infrequent sessions at the rate of one a week or less often. In the London Region there is greater activity; less than half the clinics hold infrequent sessions as above defined.

Alternatively, this index may be expressed in the following form:

Type of Clinic.	No. of Clinics.	Average Number of Clinic-Sessions per Week.
A	81	1·37 ± ·10
B	69	1·02 ± ·02
C	39	2·62 ± ·47
	189	All differences are significant.

As between the regions, the number of clinics involved are too small for sound statistical analysis, but it may be pointed out that for the country as a whole, 11 clinics held sessions monthly or less often, 10 of these being in Wales; and 20 clinics held fortnightly sessions. At the other extreme are clinics such as the Tavistock Clinic

in London which in normal times holds sessions continuously on mornings, afternoons and evenings by the appointment system. Of the 192 clinics, 109 held sessions once a week.

(ii) DOCTORS ATTENDING EACH SESSION.

Some clinics held more than one session in the week. These sessions might be attended by differing numbers of doctors—two on Friday mornings and one on Tuesday afternoons, for instance. The average number of doctors attending the sessions of a given clinic may therefore not be a whole number.

Psychiatric clinics have been classified in terms of the average number of doctors attending each session. The results (Table VII) show, as is to be expected, that the proportion of clinics with more than two doctors per session is higher in the 'A' type large-town clinics outside London than in the 'B' type small-town clinics, and that the proportion in the 'C' type London clinics is still higher. The relevant information was available for 191 clinics.

TABLE VII.—*Clinics distributed by Number of Doctors per Session in (A) C.B.s outside London; (B) Administrative Counties outside London; (C) the London Region.*

Doctors per Session.	Administrative Area.							
	A.		B.		C.		Total.	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Two and under	57	69·5 [1]	61	87·1 [1]	19	48·7	137	71·7
Over two	25	30·5	9	12·9	20	51·3	54	28·3
Totals	82	100·0	70	100·0	39	100·0	191	100·0

[1] Difference = 17·6 ± 6·8.

The average attendance of doctors per session is directly compared in the following table:

TABLE VII (*a*).

Type of clinic	A.	B.	C.	Total.
Number of clinics	82	70	39	191
Average number of doctors per session	1·88 ± ·07	1·66 ± ·05	2·78 ± ·52	1·98 ± ·12

Difference between A and C = ·903 ± ·521.
" " A and B = ·222 ± ·09.

Comparison between the average number of doctors per session in London ('C' type) clinics with those in C.B.s outside London ('A' type) shows that the difference is not greater than might arise by chance, though the figures are suggestive. The difference between large- and small-town clinics ('A' and 'B' types) is less spectacular but more real.

(iii) DOCTOR-SESSIONS PER WEEK.

The average number of doctor-sessions per week provides a better index than the two preceding of the activity of a psychiatric clinic. This index has been calculated for 189 clinics.

TABLE VIII. *Average Number of Doctor-Sessions per Week per Clinic in (A) C.B.s outside London; (B) Administrative Counties outside London; and (C) the London Region.* 189 *Clinics.*

	Administrative Area.			
Type of clinic .	A.	B.	C.	Average.
Number of clinics.	81	69	39	
Doctor-sessions per week per clinic . .	2·05±·19	1·42±·33	4·96±1·08	2·42±·28

Difference between A and C = 2·91±1·10.
" " A and B = ·63± ·38.

Again it will be seen that the London clinics are the most active and the small-town ('B' type) clinics least; the difference between 'C' and 'A' types is significant, and that between 'A' and 'B' types, while not significant, is suggestive.

(iv) DOCTOR-SESSIONS PER WEEK PER MILLION OF POPULATION.

Figures have been calculated for each civil defence region, distinguishing the type of clinic, showing the weekly doctor-sessions per million of population. They are shown in the following table:

TABLE IX.—*Total Doctor-Sessions per Week per Million in Each of Eleven Civil Defence Regions. Period:* 1938, 1940–42. *(A) C.B.s outside London; (B) Administrative Counties outside London; (C) London Region* (1942 *only*). 189 *Clinics.*

	Civil Defence Regions.										
	I.	II.	III.	IV.	VI.	VII.	VIII.	IX.	X.	XII.	Average.
A . .	5·41	8·40	25·6	16·47	30·88	17·40	14·20	9·14	13·86	28·88	13·86
B . .	1·90	3·56	3·14	12·96	9·63	2·68	2·49	3·08	1·70	7·23	4·81
Totals .	3·23	6·27	9·55	13·40	15·81	6·72	4·94	6·17	8·18	9·71	8·16

C (1942 only), 26·68.

All figures except those underlined are under-estimates.

If all the clinics had responded fully to the questionnaire, it would have been easy to provide regional averages of doctor-sessions per week for the whole country. Where a figure in Table IX is underlined, relevant information as to doctor-sessions is available from *all* clinics in the region of the relevant 'A' or 'B' category. When a figure is not underlined, it is implied that one or more clinics of the relevant regional category failed to provide the information required. Hence figures not underlined are under-estimates of the real number of doctor-sessions available.

But granted these under-estimates, enormous regional disparities in the number of doctor-sessions will be observed. These range between a weekly provision of 26·7 doctor-sessions per million of population in London during 1942 (an under-estimate of the realities) to one of 4·9 in Wales.

In section 3 (ii) above, it was pointed out that the regions in the south of England were better served with psychiatric clinics than those in the north. Table X shows a corresponding comparison for doctor-sessions per million of population.

TABLE X.—*Average Number of Doctor-Sessions per Week per Million of Population in Regions I and X (North of England) and in Regions VI, VII and XII (South of England). (A) C.B.s; (B) Administrative Counties.*

	A.	B.	Average.
Regions I and X (North) .	12·00	1·78	6·75
Regions VI, VII and XII (South) .	24·46	6·28	10·50

It will be seen that in the three regions on the south coast, psychiatric clinics hold more doctor-sessions per million of population than are held in clinics in the two regions of the north.

SUMMARY OF MEASURES OF ACTIVITY SO FAR DISCUSSED.

Thus, by all the four indices so far considered—frequency of session, doctors attending sessions, doctor-sessions per week either in absolute numbers or else expressed in relation to the populations served—the clinics of the London area are the most and those of the small towns the least active. The activity of clinics is further examined in sections 11 and 12 below, in terms of clinic attendances.

7. Accessory Services.

(i) Inquiries were made as to the use made in psychiatric clinics of the following accessory services: psychiatric social workers (P.S.W.s),

social workers (S.W.s) or almoners, psychologists, and speech-therapists. Information was obtained from 192 out of 216 clinics, 41 belonging to the London Region. The main findings are set out in the following table:

TABLE XI. *Psychiatric Clinics using Accessory Services in (A) C.B.s outside London; (B) Administrative Counties outside London; and (C) the London Region.* 192 *Clinics.*

		Administrative Area.							
		A.		B.		C.		Total.	
Clinics giving Relevant Information . .		81		70		41		192	
		No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Clinics having	P.S.W.s . .	20	24·7	29	41·4	17	41·5	66	34·4
	S.W.s or almoners .	34	42·0	12	17·1	21	51·2	67	34·9
	Psychologists .	4	4·9	7	10·0	9	22·0	20	10·4
	Speech therapists .	7	8·6	6	8·6	6	14·6	19	9·9

P.S.W.s: Difference between A and B=16·7±7·6.
S.W.s and almoners: Difference between A and B=24·9±6·9.

From the above table it can be seen that, of the 192 known clinics, just over a third (34·4 per cent) have psychiatric social workers, a slightly larger proportion (34·9 per cent) have social workers or almoners, just over a tenth (10·4 per cent) have psychologists, and just under a tenth (9·9 per cent) have speech therapists; that 41·4 per cent of the small-town (B) clinics have psychiatric social workers in contrast to 24·7 per cent of the large-town (A) clinics; and that the large-town clinics are better served by almoners and social workers.

The difference between the two types of clinic as to psychiatric social workers is probably connected with the fact that proportionately more small-town clinics than large are staffed by psychiatrists based on Mental Hospitals and that many Mental Hospitals employ psychiatric social workers who help with the out-patient work. Social workers and almoners, on the other hand, are much used in the large hospitals wherein are located many of the psychiatric clinics of big towns.

(ii) The eleven regions were found to vary much in the use they made of accessory services. None of the known clinics in Regions I, II, VIII, IX or X had either a psychologist or speech therapist. And regions in the south are better served than those in the north-east by psychiatric social workers, social workers and almoners. Thus Regions VI, VII and XII, which form the south coast of England,

average over thirteen of these workers each ; while Regions I and II (Northumberland, Durham and Yorkshire) have nine between them.

8. Reception of Children.

(i) Clinics were asked if they received and treated children and, if yes, whether the children were seen at the same sessions as adults or at special children's sessions. Replies were received from 187 out of 216 clinics. The main findings are shown in Table XII.

TABLE XII.—*Psychiatric Clinics classified according to Arrangements for Reception of Children in (A) C.B.s outside London ; (B) Administrative Counties outside London ; and (C) the London Region.*

Children:—	Administrative Area.							
	A.		B.		C.		Total.	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Seen at special sessions	7	8·7	5	7·4[1]	8	20·5[1]	20	10·7
Seen at same sessions as adults	63	78·8	57	83·8	25	64·1	145	77·5
Not received	10	12·5	6	8·8	6	15·4	22	11·8
Totals	80	100·0	68	100·0	39	100·0	187	100·0

[1] Difference = 13·1 ± 6·55.

(ii) It is suggested by some of the answers to the questionnaire that the growth of Child Guidance Clinics has affected the arrangements of psychiatric departments for dealing with children. If a Child Guidance Clinic is part of a psychiatric clinic established in a hospital, that clinic will receive children at special sessions. But if the Child Guidance Clinic is located, not in a hospital but near by, the hospital may refer children to the clinic and not itself receive them.

(iii) There are the usual regional variations : at none of the known clinics in Regions I, IX and X are children seen at special sessions ; and in Regions II, III and VIII there are no clinics which fail to receive children. The London Region has the highest proportion of clinics which receive children at special sessions—8 clinics out of 39, or 20·5 per cent. The corresponding proportion of small-town 'B' clinics is 7·4 and the difference from London, while suggestive, is not quite significant. More clinics in London than elsewhere have differentiated their functions to meet the needs of children, but in general the differences in the arrangement for reception of children are not significant.

With the development of child psychiatry we can hope to see an increase of clinics which receive children at special sessions.

9. Pressure on Psychiatric Clinics.

(i) The Directors of psychiatric clinics were asked the following question: 'During the war years, has the pressure on your clinic ever been such as to necessitate a refusal to treat patients?' If the answer was 'yes', the clinic was treated as having experienced pressure. Information was given by 190 clinics, and the results are summarized in Table XIII.

TABLE XIII.—*Psychiatric Clinics classified in accordance with whether or not they experienced pressure. (A) C.B.s outside London; (B) Administrative Counties outside London; and (C) the London Region.*

	Administrative Area.							
	A.		B.		C.		Total.	
No pressure . .	64	79·0[1]	55	78·6	22	56·4[1]	141	74·2
Pressure . . .	17	21·0	15	21·4	17	43·6	49	25·8
Totals .	81	100·0	70	100·0	39	100·0	190	100·0

[1] Difference = 22·6 ± 8·8.

(ii) It will be seen that of the 190 known clinics, just under three-quarters had not experienced pressure. This finding is compatible with the results of the analysis of attendances of new and return patients which are considered in Tables XIX and XX below.

(iii) There is very little difference between the proportions of large- and small-town clinics which had and had not experienced pressure—79·0 and 78·6 per cent respectively had not had pressure. But the London Region differs from the aggregates just considered: only 56·4 per cent of its 39 known clinics had not had pressure, and there is a significant difference between the aggregated 'A' clinics and those of the London Region in this respect.

(iv) The amount of pressure varied in different regions: thus of the 34 clinics in Regions VIII and XII (and all the clinics in these regions gave the relevant information), not one had been pressed; and of the 20 known clinics in Regions I and VII, only one in each reported pressure. Conversely, of the 71 known clinics in Regions III, V and VI, 31 recorded pressure. Two out of 14 only of the known clinics in the West Riding conurbation (Region II) had known pressure; but 8 out of the 23 clinics in the Lancashire conurbations, included in Region X, had been pressed.

(v) An attempt was made to divide clinics in evacuation from those

in reception areas, and to compare their experiences of pressure. But the available information was insufficient, especially of those areas which, at one phase of the war period under review, were reception and at another evacuation areas.

Hitherto, no reference has been made to attendances of patients at psychiatric clinics. These attendances will now be considered from various standpoints.

10. Clinic-Years.

(i) In Section 2 above, certain particulars were given as to how the questionnaire was filled in; this matter will now be examined from another aspect.

The questionnaire used in the survey asked for figures of attendances relating to the four years 1938, 1940, 1941 and 1942. A clinic founded before 1938, remaining open till after 1942 and giving the information required, would therefore furnish particulars of *four clinic-years*. Of the 216 clinics in England and Wales, however, 30 did not fill in the questionnaire (see Table I (*a*)), and it was not known of some others when they were established. Indeed, this information was lacking of 39 clinics (Table V). As remarked earlier, of the 42 clinics in the London Region, those which supplied figures for attendances gave them for the year 1942 only. Six clinics (2 in Region VIII and 4 in Region II) were suspended during the war and therefore gave figures for less than four clinic-years; and the same can be said for 10 clinics which were established after 1939.

(ii) The position is summarized in Table XIV.

TABLE XIV.—*Clinic-Years: Actual and 'Possible' Figures for New Patients during* 1938, 1940, 1941 and 1942. (*A*) *C.B.s outside London;* (*B*) *Administrative Counties outside London;* (*C*) *the London Region* (1942 *only*).

	Administrative Area.			
	A.	B.	C.	Total.
(*a*) Number of clinic-years for which figures for new patients are available .	240	216	35	491
(*b*) Number of clinic-years for which figures for new patients might have been provided . . .	352	288	42	682
Percentage (*a*) of (*b*) .	68·2	75·0	83·3	72·0

It will be seen that figures as to new patients were provided for 491 out of a possible 682 clinic-years, or for 72·0 per cent of possible clinic-years. The percentages of type 'A,' 'B' and 'C' clinics which provided figures—68·2, 75 and 83·3 per cent—show differences which are not quite significant, so that the data provided for these three groups are generally comparable.

(iii) There were conspicuous variations in how different regions provided figures. These ranged from Region VIII (Wales), which gave figures for 100 per cent of possible clinic-years, to Region II, which gave figures for 36·5 per cent of possible clinic-years. Region X (including Lancashire) gave full figures—91·2 per cent of possible clinic-years. Only one region (II, the West Riding of Yorkshire) provided a minority sample—under 50 per cent.

11. New Patients.

(i) TOTALS OVER THE FOUR YEARS : 491 CLINIC-YEARS.

(*a*) During the 491 clinic-years for which information is available, 51,601 new patients were seen. The position is summarized in Table XV.

TABLE XV.—*New Patients attending Psychiatric Clinics : Average Number per Year during* 491 *Clinic-Years throughout* 1938, 1940, 1941 *and* 1942. (*A*) *C.B.s outside London ;* (*B*) *Administrative Counties outside London ;* (*C*) *the London Region* (1942 *only*).

Year.	Administrative Area.								
	A.			B.			Totals.		
	No.	Clinic-Years.	Average Patients per Clinic per Year.	No.	Clinic-Years.	Average Patients per Clinic per Year.	No.	Clinic-Years.	Average Patients per Clinic per Year.
1938 .	6,300	56	112·5	2,056	51	40·3	8,356	107	78·1
1940 .	6,049	60	100·8	2,025	53	38·2	8,074	113	71·4
1941 .	6,582	60	109·7	3,019	55	54·9	9,601	115	83·5
1942 .	8,455	64	132·1	4,096	57	71·9	12,551	121	103·7
Totals	27,386	240	114·1	11,196	216	51·8	38,582	456	84·6
C. London Region (1942 only) : 13,019 new patients were seen in 35 clinic-years. Average patients per clinic-year is 372·0.									
Grand Total : 51,601 new patients were seen in 491 clinic-years. Average patients per clinic-year is 105·1									

(*b*) The totals excluding London show a drop in 1940 below the figure for 1938, followed by a rise in 1941 to a point above the 1938 level, and by a still further rise in 1942. This trend is reflected by the figures for both 'A' and 'B' type clinics. The increase is specially marked

in small-town ('B' type) clinics, the new patients in 1942 being very nearly double those in 1938—4096 patients against 2056, there being 57 clinic-years in 1942 against 51 in 1938.

(*c*) The trend shown by the totals—a drop in 1940 below the level for 1938, followed in 1941 by a rise above that level, and by a still larger rise in 1942—is reflected in four of the regions—VI, IX, X and XII. But as usual, regions varied. A straight rise throughout the period is shown in Regions I, III and IV; and other distributions, each different, are shown in Regions II, VII and VIII. Only one region—namely, VIII (Wales)—shows a lower figure for 1942 than for 1938. This region's figures for the four years are :

1938	816 in 15	clinic-years.
1940	505 in 15	„
1941	489 in 14	„
1942	691 in 14	„

(*d*) Noteworthy differences are at once obvious in the averages for large-town and for small-town clinics and for clinics in London; if the three figures for the year 1942 are compared (this being the only year for which London clinics provided information), they will be seen to be 132·1, 71·9 and 372 respectively. These figures imply that, in an average week, there were seen at the average clinic in the three areas the following number of new patients: 2·54, 1·38 and 7·15.

(*e*) The averages for small-town clinics show a smaller fall in 1940 than do those for large, followed by a more marked rise afterwards. Part of the increase in small-town clinics may have been due to evacuation, without which the trends, both in large- and small-town clinics, might have been different.

(*f*) The average number (114·1) of new patients seen at large-town clinics throughout the four years is more than twice as large as the corresponding number seen at the corresponding small-town clinics (51·8).

(*g*) Throughout the eleven regions there is considerable variation in the average number of new patients per year. The range extends from the London Region with 372 new patients per clinic in 1942, to Region VIII with an average of 43 over the four years, and of 49 in 1942 (less than one new patient per week). The figure for the London Region in 1942 is more than three times higher than that for the region with the next highest average figure for the four years (Region I with 125 new patients).

(*h*) Figures for new patients seen in London clinics are available for 1942 only. In that year more new patients were recorded, in the answers to the questionnaire, as having been seen in London clinics than in those of the whole of the rest of the country put together—13,019 patients in London against 12,551 in the provinces. But these figures cannot be taken at face value because different proportions of large-town, small-town and London clinics which received patients in 1942, failed to collaborate in the inquiry and to fill in the questionnaire.

In 1942, 10 out of the 216 clinics covered by the inquiry were closed, leaving 206 which received patients. Figures as to new patients in that year were provided as follows :

Large-town clinics	64	clinics out of a possible of	92
Small-town ,,	57	,, ,, ,,	73
London ,,	35	,, ,, ,,	41
Total	156		206

If the number of new patients per clinic per annum for the clinics which were open in 1942, but failed to give the relevant figures, had been the same as for other clinics of their type, we should have the following results :

Estimated Number of New Patients received by 206 Psychiatric Clinics in 1942.

	No.	Per Cent.
Large-town clinics	12,154	37·2
Small-town ,,	5,246	16·1
London ,,	15,251	46·7
Total	32,651	100·0

This is the nearest estimate at present available of the total number of new patients attending the psychiatric clinics of England and Wales in a single year. It will be seen that a little less than half—46·7 per cent—were seen in London.

One of the main findings of the neurosis survey has been that psychiatric clinics situated in London (type 'C'), in County Boroughs (type 'A') and in Administrative Counties (type 'B') show varying standards of activity. The criteria by which activity is estimated were discussed on page 137. The matter is here raised because it has a bearing on the adequacy of existing psychiatric out-patient services for future needs.

There is little doubt that the three areas above considered vary in what has been called ' psychiatric awareness '. Psychiatric problems are better understood both by doctors and lay people in London than in the provinces, and in the County Boroughs than in the Administrative Counties. We can reasonably expect that, in the future, psychiatric awareness will spread, and that such services as are established will be increasingly used, especially for early cases and for cases of neurosis.

What, we may ask ourselves, would be the effect on clinic attendances if provincial psychiatric clinics were attended by the same proportion of the population as are the London clinics ? The figures for the populations of the three areas (A, B and C) are given in Appendix III ; they are averaged for the years 1938, 1940, 1941 and 1942, but will serve roughly to compare London with the provinces in

respect of the proportions of the population who made a first visit to psychiatric clinics in 1942.

Here are the figures :

TABLE XV (*a*).

	Populations : Averages over 1938, 1940, 1941 and 1942. (*a*)	Estimated Number of First Attendances at Psychiatric Clinics in 1942. (*b*)	Estimated First Attendances per 100 Population. (*c*)
London (Region V) .	7,232,611	15,251	·21086
Provinces .	32,345,635	17,400	·05379
Totals .	39,578,246	32,651	·08249

It will be seen from column (*c*) that, in proportion to population, just under four times as many Londoners are estimated to have attended psychiatric clinics for the first time in 1942 as did persons in the provinces. If provincial attendances had been on the same scale per population as London, there would, according to the estimated figures in column (*b*) have been, in 1942, 68,209 first attendances at provincial clinics, and 83,460 in England and Wales as a whole (London included). This last figure is between twice and three times as large as the estimated number of actual new attendances at clinics in 1942 (32,651 patients).

But these estimates must be interpreted with great caution for reasons set out on page 163, where a similar calculation will be found of new patients diagnosed as suffering from neurosis.

(ii) NEW PATIENTS : TOTALS OVER THE FOUR YEARS : 416 CLINIC-YEARS.

(*a*) Table XV gave figures for a total of 456 clinic-years excluding the London Region. But it will be seen that the annual totals of clinic-years varied in the four years, being 107 in 1938, 113 in 1940, 115 in 1941 and 121 in 1942. Some clinics closed after 1938, some opened for the first time after that date, and some were unable to give figures for all the four years. The reader may therefore feel some doubt as to whether the trends of the averages give a real picture of the position or whether they are but the result of the annual variation in the number of working clinics. I have therefore completed the picture by presenting figures based on the returns of clinics which provided data for the whole period asked for ; 104 clinics gave figures for all four years—a total of 416 clinic-

years. The new patients seen at these 104 clinics are shown in the following table :

TABLE XVI.—*New Patients and Average New Patients per Year attending* 104 *Psychiatric Clinics in the Years* 1938, 1940, 1941 *and* 1942 *shown separately—*416 *Clinic-Years. (A) C.B.s outside London ; (B) Administrative Counties outside London.*

Year.	Administrative Area.								
	A.			B.			Totals.		
	No.	Clinic-Years.	Average Patients per Clinic per Year.	No.	Clinic-Years.	Average Patients per Clinic per Year.	No.	Clinic-Years.	Average Patients per Clinic per Year.
1938 .	6,268	55	114·0	2,052	49	41·9	8,320	104	80·0
1940 .	5,471	55	99·5	1,951	49	39·8	7,422	104	71·4
1941 .	5,880	55	106·9	2,348	49	47·9	8,228	104	79·1
1942 .	7,465	55	135·7	3,009	49	61·4	10,474	104	100·7
Totals	25,084	220	114·0	9,360	196	47·7	34,444	416	82·8

The figures of the London Region which relate to 1942 only are here excluded.

(*b*) The trend of the totals differs from that shown in Table XV. There is here a fall in 1940 below the level for 1938 ; a rise in 1941 above the level for 1940, but not attaining to the level of 1938 ; and a conspicuous rise in 1942 to well above the level for 1938.

(*c*) The figures of 'A' clinics for the four years bear the same relation to each other as do those of the totals, *i.e.* fewer patients were seen in 1940 and 1941 than in 1938 ; those for 'B' clinics bear the same relation to each other as do the figures for the totals in Table XV, *i.e.* more patients were seen in 1941 than in 1938.

(*d*) The average number of new patients per year throughout the four years is 114·0 for 'A' type clinics and 47·7 for 'B' type. The difference is greater than that shown in Table XV.

(iii) NEW PATIENTS : ATTENDANCES PER CLINIC-SESSION.

(*a*) Particulars as to the number of new patients per clinic-session are available for 158 psychiatric clinics. The averages provide another index of the activity of clinics. In Table XVII are shown the numbers and percentages of clinics receiving on average small numbers of new patients per session.

[TABLE XVII

TABLE XVII.—*Numbers and Percentages of Psychiatric Clinics receiving on Average less than One and less than Two new Patients per Clinic-Session averaged for Years* 1938, 1940, 1941 and 1942. (*A*) *C.B.s outside London*; (*B*) *Administrative Counties outside London*; (*C*) *London Region* (1942 *only*).

New Patients received per Clinic-Session.	Administrative Area.							
	A. 64 Clinics.		B. 59 Clinics.		C. 35 Clinics.		Totals. 158 Clinics.	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Less than one .	17	26·6	28	47·5	5	14·3	50	31·6
Less than two .	45	70·3	48	81·4	8	22·9	101	63·9

(*b*) Thus, of 158 known clinics, there came to 31·8 per cent less than one new patient per clinic-session, and to 63·9 per cent less than two new patients. The percentages of A, B and C types of clinic in the two categories differ, but not to an extent which is statistically significant.

(*c*) The totals of 'known' clinics in individual regions are small, and the proportions receiving less than two new patients per clinic-session vary much. The proportions range between the London Region with a figure of 22·9 per cent, as shown above, and Region X with a figure of 90·5 per cent. Region IV is the only region other than London with a percentage below 50.

(*d*) Only 29 clinics out of the 158 (of which 18 were in the London Region) received on average more than three new patients per session.

(iv) NEW PATIENTS : ATTENDANCES PER DOCTOR-SESSION.

(*a*) In estimating the activity of a psychiatric clinic, we finally get down to the doctor-session. But the average number of patients then seen throws light on the general organization of the clinic rather than on its activity. It was suggested above (on page 72) that there is an optimum number of patients which a psychiatrist can most efficiently deal with in a doctor-session of three hours—and no doctor-session should last longer than three hours. This optimum depends on whether a psychiatric social worker is available to take the social and domestic history ; if this assistance is not to hand, the psychiatrist cannot be expected to deal properly with a new patient in under an hour ; and he should be allowed ten to fifteen minutes to see every old patient who is not receiving a course of psychotherapy. A psychiatric clinic whereat the psychiatrist has to prolong his session beyond three hours, and whereat he is asked to see more new and old patients than can be fitted into this period according to the above scale, is asking

too much of its staff who cannot give their best ; conversely a psychiatric clinic which provides an insufficient number of patients to occupy fully the psychiatrist's time is not making the best use of its specialist personnel. The optimum number of new and old patients can only be rationed to the available medical staff if an appointment system is followed. The number of new patients attending the average doctor-session will therefore reflect on the clinic's organization rather than its activity. If the clinic is active in the sense of dealing with a large number of patients, it should not show unduly high attendances at doctor-sessions ; it should show, rather, a generous number of clinic- and doctor-sessions. Too many patients per doctor-session indicates not healthy activity but unhealthy pressure. It is important to distinguish between the two. The following table should be interpreted in the light of the above considerations.

TABLE XVIII.—*New Patients per Doctor-Session : Averages for Years* 1938, 1940, 1941 *and* 1942 *in* (*A*) *C.B.s outside London ;* (*B*) *Administrative Counties outside London ; and* (*C*) *the London Region* (1942 *only*). 480 *Clinic-Years.*

	Administrative Area.			
	A.	B.	C.	Total.
Clinic-years . .	239	208	33	480
Total new patients .	27,386	10,511	12,919	50,816
Total doctor-sessions .	27,282	16,045	9,150	52,477
New patients per doctor-session . .	1·00	0·66	1·41	0·97

(*b*) A word about how doctor-sessions were calculated. Doctor-sessions, if recorded as being held weekly, were counted as numbering 50 in the year. It happens in many clinics that sessions are not held on bank holidays and feast days, so that if sessions are recorded as being held weekly it might be an over-estimate to count 52 in the year. Various arrangements are also made to meet the contingencies of holidays, illness and other unavoidable absences on the part of the medical staff. When two doctor-sessions are held simultaneously, the commonest adjustment is for holidays to be staggered, when one doctor sees his colleague's patients.

It is not always possible to give in a return the precise number of doctor-sessions held at a given clinic in a year. The figures given in Table XVIII may be an over-estimate.

(*c*) Table XVIII shows that, for the 480 clinic-years for which information is available, an average of just under one new patient (0·97) per doctor-session was seen. This certainly does not suggest that the psychiatric clinics of the country as a whole are subjected to a great pressure of patients.

(*d*) The three administrative areas show the usual differences.

12. First and Return Attendances.

(i) NUMBERS.

(*a*) A comparison of the returns of different clinics show that there is considerable variation in the number of return attendances. At one extreme are those clinics which are mainly diagnostic, many of these being used as portals of entry for Voluntary and other patients into Mental Hospitals; at the other extreme are clinics which specialize in psychotherapy. Of the latter, the active Tavistock Clinic and the Institute for Psycho-analysis are examples.

In interpreting the comparative numbers of new and return attendances, we should not assume that the proportion of return cases gives a strictly accurate index of the amount of psychotherapy practised in the clinic. It can easily happen that, in a clinic which receives more patients than it can properly deal with, the new cases are hurriedly seen, and no satisfactory decision is reached as to disposal. The patient is told to come up in a week when he may be seen by another doctor, who does not make the essential decision. The patient then becomes a regular attendant; the doctor is apt to spend little time on such cases—enough for an inquiry as to the patient's condition and for prescribing a repetition of the medicine which the patient finds suits him best. Such a clinic falls into the habits which necessarily prevail in a neurological out-patient clinic for epileptics, who are kept under regular observation and come up at fixed times to renew supplies of their drug. Nevertheless, the number of return visits provides some indication of how far a clinic is prepared to supplement diagnosis by treatment.

The survey yielded figures as to both new and return attendances covering 472 clinic-years. The main findings are summarized in the following table:

TABLE XIX.—*New and Return Attendances: Percentages of First among Total Attendances covering* 472 *Clinic-Years in* (*A*) *C.B.s outside London;* (*B*) *Administrative Counties outside London; and* (*C*) *London Region* (1942 *only*).

	Administrative Area.			
	A.	B.	C.	Total.
Clinic-years . .	225	212	35	472
(*a*) Total attendances .	138,381	58,384	95,882	292,647
(*b*) First attendances .	25,461	11,045	13,019	49,525
Percentage (*b*) of (*a*)	18·4	18·9	13·6	16·9

Difference between A and B = ·5 ± 0·19.
„ „ C and A = 4·8 ± 0·15.

(*b*) The three areas show the usual differences. If he bears in mind that the smaller percentage in the bottom line, the larger is the proportion of return to first attendances, the reader will observe that, at small-town ('B' type) clinics, there were relatively fewer return attendances than at the large-town ('A' type) clinic; and that, at clinics in the London Region, in 1942, the relative proportion of return attendances is much higher than it is in the other areas over the four years.

(*c*) There are the usual regional variations: they range from Region V (London) where the percentage of first among total attendances was 13·6 in 1942, as shown above, to Region I where the percentage over 17 clinic-years was 36. In the small-town ('B' type) clinics of Region VIII (Wales), the percentage during 46 clinic-years was 63·6. This implies that there were less than four return attendances to every six new patients.

(ii) CLINICS GRADED BY RATIO OF TOTAL TO FIRST ATTENDANCES.

(*a*) The position as to first and return attendances can be examined from another angle. Clinics can be graded in accordance with the ratio between the two figures. Since first attendances are all made by new patients, and since the total attendances include the first, the total attendances will be less than twice the first if the number of return attendances is less than that of new patients; and the total attendances will be less than three times the first if the number of return attendances is less than twice the number of new patients. If, at a given clinic, the ratio of total to first attendances is under three, it is improbable that the clinic concerns itself much with systematic psychotherapy or even with treatment. The position is summarized in the following table:

TABLE XX.—*Total÷First Attendances: Numbers and Percentages of Clinics where Quotient is under Two and under Three. (A) C.B.s outside London; (B) Administrative Counties outside London; (C) London Region* (1942 *only*). 153 *Clinics.*

	Administrative Area.							
	A.		B.		C.		Total.	
Clinics: numbers .	60		58		35		153	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Clinics where Total÷First Attendances is:								
(*a*) Under two .	7	11·7	21	36·2	Nil	Nil	28	23·7
(*b*) Under three .	17	28·3	33	56·9	6	17·1	56	36·6
(*c*) Three and over .	43	71·7	25	43·1	29	82·9	97	63·4
Total (*b*) + (*c*) .	60	100·0	58	100·0	35	100·0	153	100·0

(*b*) The table shows that, of the known clinics in the country as a whole, a little over a third (36·6 per cent) received, in the period under review, less than two return attendances for each new patient; and a little under a quarter (23·7 per cent) received less than one return attendance for every new patient. The percentages vary in the three administrative areas in ways we have been led to expect.

(*c*) The percentages in question vary much from region to region. At one extreme is Region VIII (Wales) where 14 out of the 16 total clinics (87·5 per cent) received less than two return attendances for every new patient; and at the other is Region IV (South-East) where only 1 out of 7 'known' clinics (14·3 per cent) was in this position.

(*d*) These figures therefore suggest that clinics in London concern themselves more with treatment than do clinics in County Boroughs outside London and in Administrative Counties, taken as a whole; and that the large-town ('A' type) clinics show the same contrast with those of small towns ('B' type).

13. Admissions to Hospital.

(i) NUMBERS AND CATEGORIES.

(*a*) The questionnaire asked for figures as to the admission to hospital from psychiatric clinics of two categories of patients: the first comprised Temporary and Certified cases; the second Voluntary and 'Other' cases. These categories call for some explanation.

The Mental Treatment Act (1930) was mainly designed to facilitate the early treatment in Mental Hospitals, and without recourse to certification, of patients suffering from probably transitory mental disorders. The word 'voluntary', as applied to the process by which a patient enters a hospital, has a popular and a statutory meaning, the latter being generally recognized in the expression 'Voluntary patient'. In the popular sense, most patients who enter General Hospitals, for the treatment of any physical ailment, do so voluntarily: that is to say that there are no legal formalities. But in the statutory sense of the word as used in the Mental Treatment Act, the Voluntary patient is required to sign a declaration of willingness to enter a hospital approved for the purpose; the Superintendent has certain legal obligations as to what he must do if the patient gives notice of a wish to be discharged; and the hospital receiving such a Voluntary patient becomes subject to periodic inspection by a Commissioner of the Board of Control, who is invested with powers. The hospital must, moreover, be approved by the Board.

A Temporary patient is one who is incapable of expressing willingness or unwillingness to be admitted to a hospital, and is usually in a more serious mental condition than is the Voluntary patient; the number of Temporary patients admitted to hospitals under the Mental Treatment Act is much smaller than the number of Voluntary.

For the purposes of the questionnaire, therefore, the Temporary and Certified categories were grouped together to include relatively durable or serious forms of mental disorder; while the Voluntary and Other categories are combined to include relatively mild or transient forms.

Temporary and Certified patients mostly suffer from psychoses, the incidence of which is not likely to be much affected by the war. In any case, figures provided by the annual reports of the Board of Control are fully representative and accurate, while the figures here given form but a small sample.

By Voluntary patients are meant those so defined in the Mental Treatment Act; by 'Other' patients, those who are admitted to hospital on psychiatric grounds, but without legal formalities and without reference to the Mental Treatment Act. 'Other' patients are admitted as are sufferers from physical illnesses to a General Hospital. Among Voluntary and 'Other' admissions, are cases of neurosis the incidence of which may have been affected by the war. 'Other' cases are not included in the reports of the Board of Control.

(*b*) Information as to the admission of these two categories of patient to hospital was obtained for 431 clinic-years of 37,756 new patients. The position is summarized in the following table:

TABLE XXI.—*Admissions to Hospital from Psychiatric Clinics of Temporary+Certified (T. & C.), and of Voluntary+Other (V. & O.) Patients during* 1938, 1940, 1941 *and* 1942 *for (A) C.B.s outside London; (B) Administrative Counties outside London; and (C) the London Region* (1942 *only*).

	Administrative Area.			
	A.	B.	C.	Total.
Clinic years . .	216	188	27	431
Relevant new patients .	21,614	8,628	7,514	37,756
Admissions to hospitals:				
T. & C. cases . .	510	523	119	1,152
V. & O. cases . .	3,296	1,596	1,239	6,131
Totals .	3,806	2,119	1,358	7,283

(ii) PERCENTAGES OF TOTAL NEW PATIENTS.

(*a*) Comparison is facilitated if the figures given in the preceding table are reduced to percentages. The results are shown in the following table:

TABLE XXII.—*Percentages of Total new Patients admitted to Hospital during* 1938, 1940, 1941 *and* 1942 *from Psychiatric Clinics as Temporary or Certified (T. & C.) Patients and as Voluntary or Other (V. & O.) Patients from (A) C.B.s outside London; (B) Administrative Counties outside London; and (C) the London Region* (1942 *only*).

Admission Group.	Administrative Area.			
	A. Clinic Years. 216	B. Clinic Years. 188	C. Clinic Years. 27	Total. Clinic Years. 431
T. & C. .	2·4	6·1	1·6	3·1
V. & O. .	15·2	18·5	16·5	16·2
Totals .	17·6	24·6	18·1	19·3

Total admissions: Difference between A and B = 7·0 ± 0·5.
T. & C. admissions: „ „ „ = 3·7 ± 0·23.
„ „ „ „ B and C = 4·5 ± 0·31.
V. & O. „ „ „ A „ B = 3·3 ± 0·47.

(*b*) The average percentage of patients (all categories) admitted to hospital for all regions including London is seen to be 19·3 or just under one new patient in five. Of these admissions, more than four-fifths went in as Voluntary or Other patients. There are marked regional variations in total admissions to hospital; the extremes are Region I (36·3 per cent only of 'possible' clinic-years) with 6·7 hospital admissions per 100 new patients, and Region VIII (100 per cent of possible clinic-years) with 25·5 hospital admissions per 100 new patients.

(*c*) Admissions of Temporary and Certified patients to hospital average 3·1 per cent for the whole country; in different regions they vary between London with an admission rate of 1·6 per cent of new patients as shown, and Region XII with a corresponding figure of 8·0 per cent. Admissions of Voluntary and Other patients average 16·2 per cent for the whole country; in different regions they range from Region I with a percentage of 5·7 and Region IV with a percentage of 21·7. But these figures are not to be treated as entirely reliable, since they respectively represent 36·3 per cent and 51·9 per cent only of possible clinic-years.

(*d*) Table XXII shows that from small-town ('B' type) clinics, 24·6 per cent of new patients were admitted to hospital, while the corresponding figure for large-town clinics ('A' type) is 17·6 per cent. There is also a difference in hospital admission rates from small- and large-town clinics in respect of the T. & C. and the V. & O. categories when separately considered.

(*e*) A large admission rate to hospital is subject at least to two

quite different interpretations. The first is that adequate in-patient facilities are available for all who may need them; the second is that the psychiatric clinic which arranges the admissions may be utilized by the general practitioners of the area not so much for obtaining a diagnosis and treatment of early or mild cases among which neuroses largely figure, but rather for the disposal of severe cases who need hospital treatment—in other words, as channels of entry into Mental Hospitals. The latter construction receives support from the significantly lower percentage of Temporary and Certified cases shown in Table XXII as having been admitted to hospital from clinics in the London Region (1·6 per cent) contrasted with the percentage for the small-town ('B' type) clinics (6·1 per cent)—though allowance has to be made for the fact that in London many cases destined for Mental Hospitals are sent to observation wards of which there are few in the provinces. Clinics in the London Region are more concerned than those of any other region with the treatment of neuroses; and the London Region probably has in-patient accommodation for all types of psychiatric cases which, while far from adequate, is at least as good as that of any other region.

The same conclusion is suggested by the notes made on some of the questionnaires by the Directors of small-town clinics. These declared that their clinics were mainly used to facilitate the entry of patients to hospital under the provisions of the Mental Treatment Act.

(iii) PERCENTAGES BY YEARS.

(*a*) The admissions to hospital during the four years covered by the survey were also compared. The main findings are shown in the following tables:

TABLES XXIII AND XXIV.—*Percentages of Relevant New Patients admitted to Hospital as Temporary and Certified (T. & C.) Cases and as Voluntary and Other (V. & O.) Cases in Each of the Years* 1938, 1940, 1941 *and* 1942 *from (A) C.B.s outside London; (B) Administrative Counties outside London; and (C) the London Region* (1942 *only*).

TABLE XXIII.—Temporary and Certified patients.

Year.	Administrative Area.			
	A.	B.	C.	Totals.
1938 .	2·78	8·13	..	4·09
1940 .	2·72	7·66	..	4·00
1941 .	2·33	5·68	..	3·33
1942 .	1·81	4·43	1·6	2·65 omitting London 2·19 including „
Average .	2·36	6·06	1·6	3·42 omitting London 3·05 including „

TABLE XXIV.—Voluntary and Other patients.

Year.	Administrative Area.			
	A.	B.	C.	Totals.
1938 .	14·90	18·56	..	15·79
1940 .	15·28	19·46	..	16·37
1941 .	16·56	20·23	..	17·65
1942 .	14·47	16·75	16·5	15·20 omitting London 15·76 including ,,
Average .	15·25	18·50	16·5	16·18 omitting London 16·24 including ,,

(*b*) Table XXIII shows a steady diminution each year in the percentage of new patients admitted to hospital as Temporary and Certified cases; and Table XXIV shows an increase in the percentage of new patients admitted to hospital as Voluntary and 'Other' patients from 1938 to 1941, followed in 1942 by a drop to below the level for 1938.

(*c*) Many factors have doubtless influenced the trends of Temporary +Certified and of Voluntary+'Other' patients throughout these four years. Among these factors are probably the following:

A restriction of mental hospital accommodation (some of the best buildings in these hospitals have been temporarily taken over by the E.M.S.); perhaps a slight modification of standards—an adjustment to changed in-patient resources; an increasing utilization of psychiatric clinics for mild cases who do not require certification; and a growing appreciation of the provisions of the Mental Treatment Act for the Voluntary patient.

It is not possible to separate these factors. But the survey has given no foundation for the belief that an increase in the graver forms of mental disorder has been among the effects of the war.

14. Incidence of Neurosis and Psychosis.

(i) The questionnaire asked that every new patient should be classified according to diagnosis in one of the three following groups: neurosis, psychosis, or 'other'. A printed list of instructions and notes on the questionnaire gave the following comment:

'Question 14.—Table V, *Diagnoses*.[1] This question is designed to elucidate whether there has been a relative increase during the war years of patients seen at mental treatment centres suffering from neuroses as opposed to psychoses. The difficulties of defining these terms are fully appreciated. For purposes of this question, please treat as cases of neurosis and psychosis only those patients as to whom there is no doubt in the mind of the psychiatrist that they fall into one or other of these categories. Where doubt exists, whether from uncertainties as to the implications of

[1] See page 187.

the diagnosis or from imperfections in the records, please classify as "other".

'If the case-sheets are analysed by persons without special psychiatric experience, this question may present difficulties. On arbitrary grounds, it is suggested that the following diagnoses be construed as indicating neurosis: anxiety state, neurasthenia, psychasthenia, psychopathic personality, hysteria, obsessional state, effort syndrome, reactive (or psychoneurotic) depression and drug-addiction. Likewise on arbitrary grounds, the following may be recorded as denoting psychotic conditions: schizophrenia (dementia praecox), manic-depressive psychosis, involutional melancholia, paranoia and paranoid state, dementia, epileptic and other organic psychoses including G.P.I.'

(ii) Information was available of 45,201 new patients over the four years. Of these, 26,806 were received at large-town ('A' type) clinics, 8,628 at small-town ('B' type) and 9,767 at clinics in London ('C' type). The main findings are summarized in the following table:

TABLE XXV.—*Percentages of (I) Neurotics and (II) Psychotics among Total Relevant New Patients seen in Each of the Four Years* 1938, 1940, 1941 *and* 1942, *in (A) C.B.s outside London; (B) Administrative Counties outside London; and (C) the London Region* (1942 *only*).

(I) Neurotics

Year.	Administrative Area.			
	A.	B.	C.	Total.
1938 . .	49·7	39·0	..	47·4
1940 . .	50·5	47·4	..	49·9
1941 . .	53·2	50·9	..	52·6
1942 . .	54·2	51·8	59·3	53·6 without London 56·2 with ,,
Average . .	52·1	48·7	59·3	51·2 without London 52·9 with ,,

(II) Psychotics

1938 . .	30·3	38·3	..	32·0
1940 . .	29·8	35·3	..	31·0
1941 . .	27·6	29·6	..	28·1
1942 . .	27·6	31·5	23·5	28·7 without London 26·3 with ,,
Average . .	28·7	33·0	23·5	29·8 without London 28·4 with ,,

TABLE XXV.—*continued.*

	Neurotics.	Psychotics.
Difference between A and B .	3·4±0·62	4·3±0·56
,, ,, A and C .	7·2±0·57	5·2±0·52

(iii) The suggestion put forward above that small-town ('B' type) clinics are used more than large ('A' type) as channels by which patients are sent to Mental Hospitals rather than as centres for the treatment of neuroses, receives some support from the above figures. Three features are noteworthy.

(*a*) There has been a continuous increase in the proportions of neurotic among total patients in both 'A' and 'B' type clinics throughout the four years. The rise in the proportions between 1938 and 1942 shown by 'A' type clinics (from 49·7 to 54·2 per cent) is not as steep as the rise seen in 'B' type clinics (from 39·0 to 51·8 per cent).

This trend can be compared with a trend in the opposite direction in the figures for psychoses. These have shown a decline from 32 per cent of the total in 1938 to 28·7 per cent in 1942 (the last figures excludes London). The drop is again most marked in small-town clinics—from 38·3 to 31·5 per cent, whereas the corresponding figures for large-town clinics are 30·3 and 27·6 per cent.

(*b*) The average percentages of neurotic among total patients in 'A' and 'B' type clinics respectively during the aggregated four years are 52·1 and 48·7. There is also a difference between the percentage for London in 1942 (59·3) and for the four-year average of the County Boroughs outside London ('A' clinics), the figure for which is 52·1.

There are corresponding differences in an opposite direction in the percentages of cases of psychosis in the three types of clinic. The proportion is highest for small-town clinics (33·0 per cent), is intermediate for large-town clinics (28·7 per cent) and lowest (23·5 per cent) for London clinics.

(*c*) Information as to attendances was available for the four relevant years over the eleven regions of 51,601 patients. Information as to diagnosis (upon which the figures in Table XXV are based) is available for 45,201 or 87·6 per cent of these patients. And it should further be recalled (see Table XIV) that figures as to attendances were only provided for 72 per cent of possible clinic-years. The conclusions as to trends in neurosis and psychosis are not therefore based on the complete figures for the country as a whole, and they must be accepted with this reservation.

(iv) The question is sometimes asked: 'What proportion of people in the population suffer from neurotic disorders?'

Can this question be answered from the figures above given? In the absence of information as to the incidence of neurosis in relation to age, we can do little more at present than submit an approximate estimate of the total number of persons who were received as new

patients at psychiatric clinics and diagnosed as neurotic in a single year. The year is 1942, which is the only one for which the London Region (V) has provided figures. The position is as follows :

New patients diagnosed as neurotic in 1942 *:*

Large-town clinics .	4,527	new patients were seen at	62	clinics out of	92
Small-town clinics .	1,627	,, ,,	49	,, ,,	73
London clinics .	5,789	,, ,,	29	,, ,,	41
Totals	11,943		140		206

(Of the 216 clinics covered by the survey, 10 were closed in 1942.)

If the number of new neurotic patients per clinic per annum for the clinics which were open in 1942, but failed to give the relevant figures, had been the same as for other clinics of their type, we should have the following results :

Estimated total number of neurotic new patients received at 206 *psychiatric clinics in* 1942 *:*

Large-town clinics . .	6,717	9,141
Small-town clinics . .	2,424	
London clinics . .	8,184	
Total . .	17,325	

How do these figures relate to those for the populations of the three areas—*i.e.* the County Boroughs, which contain the large-town clinics ; the Municipal Boroughs, Urban and Rural Districts which contain the small-town clinics ; and the London Region ?

The figures for these populations are given in Appendix III. They are averages for the four years 1938, 1940, 1941 and 1942, but will again serve roughly to compare London with the provinces in respect of the proportions of the populations diagnosed as neurotic at their first visit to psychiatric clinics in 1942. The position is as follows :

TABLE XXV (*a*)

	Populations : Averages over 1938, 1940, 1941 and 1942. (*a*)	Estimated number of Neurotics first attending in 1942. (*b*)	Estimated First Attendances per 100 Population. (*c*)
London (Region V) .	7,232,611	8,184	·11315
Provinces .	32,345,635	9,141	·02826
Totals .	39,578,246	17,325	·04377

It will be seen from column (*c*) that, in proportion to population, more than four times as many neurotic Londoners are estimated as having attended psychiatric clinics for the first time in 1942 as are persons living in the provinces. Reasons are given in this report for supposing that psychiatric clinics in London are more active than those in the provinces, and that, among doctors and public, there is a higher degree of what has been called ' psychiatric awareness ' in the metropolis than elsewhere.

If, in the provinces, first attendances of neurotics at psychiatric clinics had borne the same relation to the numbers of population as they bore in London during 1942, there would have been 36,599 first attendances of neurotics at provincial clinics (large- and small-town clinics combined), and 44,783 such attendances in the 206 clinics of England and Wales which were open in 1942. This last figure is more than twice as large as the estimated figure of actual new attendances in 1942 (17,325).

These estimates provide an index of the volume of neurosis which would confront us if, in 1942, attendances at provincial clinics had been at the same rate per population as at London clinics. But we must be cautious in interpreting these figures, and especially in applying them to the conditions likely to prevail after the war. Before so applying them, we should have to assure ourselves that in London and the provinces the age composition of the population, the real incidence of neurosis, the degree of psychiatric awareness, and the available psychiatric services were equal. We should further have to assume that figures for a year of war could be taken as a guide in estimations for a year of peace. Some of these factors are known to have been different for London and for the provinces during 1942. The age composition has been affected by evacuation from London; psychiatric awareness differs as do the psychiatric services; and it is possible that the real incidence of neurosis is lower in rural districts than in large towns (the converse has been shown to hold for mental deficiency). London and the provinces are thus not *in pari materia*. Figures resulting from the application of London rates to the country as a whole must therefore be accepted with reservations.

(v) What conclusions are we entitled to draw from the figures shown in Table XXV ? Two quite different interpretations are again possible. Firstly, the figures are capable of being understood as suggesting that there has been an increase of neurosis and a diminution of psychosis in the general population during the war years. But a second and, in my opinion, more likely construction is that general practitioners are as a whole gaining confidence in the services provided by psychiatric clinics and recognizing their usefulness.

A change of attitude of this sort would result in an augmenting referral of mild or neurotic cases which would increasingly outnumber, among the new cases seen at the average clinic, the psychotic cases needing admission. The difficulties of detecting a real increase of neurosis in the general population are considerable; they have been discussed in Chapter IV (p. 14).

15. Psychiatric Air-Raid Casualties.

(i) DIFFICULTIES OF CLASSIFICATION.

The questionnaire[1] contained two questions on the subject of psychiatric casualties associated with air raids. They were drawn up so as to throw light on five problems :

(*a*) What percentage of patients dealt with by psychiatric clinics were broadly ' psychiatric air-raid casualties ' ?
(*b*) In what proportions were such cases dealt with as out- or as in-patients ?
(*c*) What proportion suffered direct physical injury in addition to the psychological trauma which brought them to the clinic ?
(*d*) Is there evidence that psychiatric air-raid casualties who had previously been recorded as having suffered from some psychiatric disability broke down more readily than those ' casualties ' with (as far as was known) no previous record of psychiatric disability ?
(*e*) Is there evidence that air-raid casualties included a larger proportion of persons with a previous history of psychiatric disability than would be found in a random sample of the population ?

In the course of the last six months of 1940 and the first six of 1941, many of the large cities of this country were subjected to heavy and sometimes to continuous air raids. The total casualties from these raids which occurred in England and Wales during the period covered by the survey are as follows :

TABLE XXVI.—*Air-Raid Casualties in England and Wales*, 1940–42.

Year.	Killed.	Injured.	Totals.
1940 . . .	23,767	30,529	54,296
1941 . .	20,881	21,841	42,722
1942 . .	3,236	4,150	7,386
Totals .	47,884	56,520	104,404

In the various psychiatric clinics in London much had been heard during the twenty years between the wars of the effects of the raids of the last war. It was perhaps this chorus of blame which gave rise to the widespread expectation that, from the severer raids of this war, would be reaped a formidable crop of psychiatric casualties. These forebodings were proved groundless by events. Indeed, the small figures which actually emerged have given substance to the view that

[1] See page 189.

the raids of the last war did not really produce the dire psychological effects which were attributed to them. It now seems that they were wrongly blamed and that many of their alleged victims would probably have developed neuroses if the raids had never occurred.

The recognition of this fact caused difficulties in devising appropriate questions to throw light on the connection between air raids and neurosis. These difficulties centre on the word 'shock'. How are we to define shock? The sound of a siren constitutes a shock to some people; and the exaggeration of unpleasant experiences is very common. Indeed, air-raid stories have been known to undergo a measurable distortion or secondary elaboration in a very short time. It has even been said that few excitable and nervous people are capable of giving a strictly accurate account of a disagreeable air-raid experience, and of consistently adhering to it in the following months and years.

It was because of these difficulties that a question was asked as to whether direct physical injury had been sustained. In the words of the leaflet of *Instructions and Notes* which accompanied the questionnaire, the question 'aims at separating persons who are involved in experiences of a direct physical character such as blast or falling masonry from those who were merely exposed to fears or to such indirect stresses as are involved in life in shelters or through evacuation. There are borderline cases—such as might be produced by the destruction of a near-by house or by deafness caused by explosions—when it is difficult to distinguish the two groups. . . . Cases should therefore only be recorded as having sustained direct physical injury when there is definite evidence, other than the patient's unsupported statement, that this occurred.'

Of the two questions about air raids contained in the questionnaire (see Appendix I), the first asked if the casualty had been treated as an out-patient or referred to hospital; and it distinguished between the years 1940, 1941 and 1942. The second question asked whether the 'casualty' had (*a*) suffered from a psychiatric disability before 1940; and (*b*) whether he had sustained direct physical injury in an air raid. And it asked for these particulars over the whole period of the three years; it did not discriminate, as had done the preceding question, between the years 1940, 1941 and 1942.

Two results may here be noted of this division of the subject. The first is that figures based on replies to the first question can be related to certain specific clinic-years, whereas those given to the second question cannot be so differentiated; the second result is that the total of figures given in the two tables do not quite accord with one another. Of a psychiatric casualty associated with an air raid, it was probably better known whether he was treated as an out-patient or referred to hospital than whether or not, before 1940, he had suffered from a psychiatric disability and whether or not he had sustained direct physical injury. It was difficult or impossible to furnish these last two particulars of a case if the records in the patient's case-sheet did not refer to them.

(ii) CASUALTIES TREATED AS OUT-PATIENTS AND ADMITTED TO HOSPITAL.

(*a*) It was observed in paragraph 11 above that the survey had provided records of attendances of 51,601 new patients covering 491 clinic-years during the years 1938, 1940, 1941 and 1942. The attendances during the last three years (1938 being omitted) were 43,245; and if the London Region is excluded, the figure is reduced to 30,226, covering 349 clinic-years.

As remarked on page 6, the surveyors of the London Region sought to lighten the very heavy tasks of the understaffed and abundantly attended London clinics by suggesting that they should provide figures of attendances for 1942 only, and that they should not answer the two questions as to air raids. Despite this proposed attenuation of their labours, 11 London clinics answered the questions now under discussion, and these have been included in the following table which is based on 28,137 new patients seen in the course of the years 1940, 1941 and 1942; and upon 310 clinic-years, of which 11 (corresponding to 3874 new patients) relate to the London Region in 1942.

TABLE XXVII.—*Psychiatric Casualties associated with Air Raids: Cases treated as Out-Patients and referred to Hospital during* 1940, 1941 *and* 1942 *from* (*A*) *C.B.s outside London;* (*B*) *Administrative Counties outside London; and* (*C*) *the London Region* (1942 *only*).

	Administrative Area.							
	A.		B.		C.		Total.	
Clinic-years .	158		141		11		310	
Total relevant new patients .	17,373		6,890		3,874		28,137	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Air-raid casualties:								
Treated as out-patients .	377	2·17	201	2·92	81	2·09	659	2·34
Referred to Hospital . .	82	0·47	35	0·51	36	0·93	153	0·54
Totals .	459	2·64	236	3·43	117	3·02	812	2·88

(*b*) It will be seen that among the 28,137 new patients there were 812 (2·88 per cent) psychiatric air-raid casualties. Of these, 659 were

treated as out-patients and 153 were referred to hospital. In other words, about four in five cases were treated as out-patients and about one in five was admitted to hospital.

(*c*) The table shows that a greater proportion of the patients attending 'B' than 'A' clinics were psychiatric casualties associated with air raids—3·43 per cent contrasted with 2·64 per cent. The difference (difference=$0·79 \pm 0·25$) is significant, and is not entirely easy to explain, seeing that small towns were less exposed to air attack than large. The complex processes of evacuation probably have something to do with it. It is possible that the evacuation from large centres of population to small may have been led by timid and neurosis-prone people who either sought treatment at, or were referred by their doctors to, the psychiatric clinics of the small towns. By contrast, those who remained behind may have been psychologically robust.

(*d*) The eleven regions varied in respect of the number of these casualties dealt with. The figures range between 129 such cases in Region X and 3 in Region I; the percentages of new patients extend from 4·60 in Region IV to 0·36 in Region I. In only four regions did these casualties exceed 100—IV, V, X and XII. In no case did they exceed 130 or 4·6 per cent of relevant new patients.

(*e*) What are we to make of these figures? Allowing for imperfections of the records, we should probably not be far wrong in regarding 3 per cent (in place of the 2·88 per cent above noted) as a fair proportion of psychiatric casualties associated with air raids in this sample of over 28,000 cases. But even if this figure is unduly low for the country as a whole (and it must be recalled that the much-bombed London Region is inadequately represented), surely it justifies some astonishment. The severity of the ordeal to which our civilian population was subjected in 1940 and 1941 is shown by the casualty lists; it is remarkable that in about only one clinic case in thirty was the disability connected by the psychiatrist with air-raid experiences.

(iii) DIRECT PHYSICAL INJURY CAUSED BY AIR RAIDS.

(*a*) Information as to the experience of direct physical injury in air raids, and as to whether or not, before the air-raid experience, the patient had suffered from some form of psychiatric disability, was obtained of 767 patients out of a total of 28,137 new patients. The fact that the total of 767 psychiatric air-raid casualties is smaller than the total of 812 on which Table XXVII was based has already been explained.

Let us first consider the experience of direct physical injury. The main facts are summarized in the following table:

[TABLE XXVIII

TABLE XXVIII.—*Psychiatric Casualties associated with Air Raids who experienced Direct Physical Injury; their Numbers and Percentages of Total Air-Raid Casualties during* 1940, 1941 *and* 1942 in (*A*) *C.B.s outside London;* (*B*) *Administrative Counties outside London; and* (*C*) *the London Region* (1942 *only*).

	Administrative Area.							
	A.		B.		C.		Total.	
Relevant new patients . .	17,373		6,890		3,874		28,137	
Psychiatric air-raid casualties . .	448		215		104		767	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Numbers and percentages sustaining direct physical injury . . .	102	22·8	34	15·8	20	19·2	156	20·3

Difference between A and B = 7·0 ± 3·3.

(*b*) It will be seen that, of 767 recorded psychiatric casualties, 156, or 20·3 per cent, sustained direct physical injury; and that the percentage is lower for small-town ('B' type) clinics than for large ('A' type), the respective figures being 15·8 and 22·8. The difference may perhaps be interpreted on the same lines as was the larger percentage found in 'B' type clinics than 'A' of psychiatric air-raid casualties among total new patients. That is to say that the patients seen at small-town clinics may have included timid and neurosis-prone evacuees who left the large towns to the occupation of people of tougher fibre. It is also possible that the large-town clinics may have had referred to them, immediately after the cessation of air raids, people suffering from shock coupled with physical injury of various degrees of gravity. Since the small towns were less bombed than the large, clinics in the former would not be likely to see patients suffering from physical injury until after they had been evacuated from the large towns; or, in other words, till after a lapse of time. In four Regions—I, II, IX and X—the small-town clinics dealt with no psychiatric casualties who sustained physical injury during air raids.

(iv) RELATION OF INCIDENCE OF PHYSICAL INJURY TO PREVIOUS EXPERIENCE OF NEUROSIS.

(*a*) The fourth question raised on page 164 above was how far a previous record of psychiatric disability might influence the readiness

with which a patient would break down under the stress of air raids. It is likely that a person with a previous history of psychiatric disability would break down under a lesser degree of stress than a person with no such history; and it is also likely that, taken as a whole, psychiatric casualties who sustained no physical injury, experienced a lesser degree of stress than those who were injured. The cases who were unhurt included some timid and excitable people who left the scenes of danger quickly, and complained of symptoms later, without having experienced stress which would be accounted severe by objective standards; those who were physically hurt, on the other hand, were involved in the physical effects of a near explosion which, according to any standard, would cause stress. Hence we should expect to find among those who were predisposed to breakdown by a previous history of neurosis, fewer cases who had experienced physical injury than among the more robust, without a previous history.

This is, in fact, what we find. The main features are summarized in Table XXIX. Here are shown the numbers and percentages of psychiatric cases who sustained physical injury distributed in accordance with: (i) whether there was no recorded psychiatric disability before 1940 (N.R.P.D.); (ii) whether a psychiatric disability before 1940 had been recorded (P.D.R.); and (iii) whether the previous psychiatric condition had not been recorded one way or the other (P.C.N.R.). In each administrative area the figure under column (*a*) gives the number of cases who sustained physical injury, that under column (*b*) gives the total number of patients in the group—that is to say, those who did and did not sustain physical injury—and column (*c*) gives the percentage (*a*) of (*b*).

TABLE XXIX.—*Psychiatric Casualties associated with Air Raids, 1940–42: Relation of Physical Injury to Previous Neurosis. For explanation, see text. (A) C.B.s outside London; (B) Administrative Counties outside London; (C) London Region (1942 only).*

	Administrative Area.												
	A.			B.			C.			Total.			
	(*a*)	(*b*)	(*c*)	(*a*)	(*b*)	(*c*)	(*a*)	(*b*)	(*c*)	(*a*)	(*b*)	(*c*)	Percentage of Total.
(i) N.R.P.D.	67	221	30·3	21	97	21·6	11	61	18·0	99	379	26·1[1]	49·4
(ii) P.D.R.	24	154	15·6	9	93	9·7	6	34	17·6	39	281	13·9[1]	36·6
(iii) P.C.N.R.	11	73	15·1	4	25	16·0	3	9	33·3	18	107	16·8	14·0
Totals	102	448	22·8	34	215	15·8	20	104	19·2	156	767	20·3	100·0

[1] Difference = 12·2 ± 3·06

(*b*) It will be seen that, of the 767 known cases, there were, as to 107 (P.C.N.R. group), no records one way or the other as to their previous psychiatric condition. Of 379 (49·4 per cent, N.R.P.D. group),

there was a record which did not include mention of any previous psychiatric disability; and of 281 (36·6 per cent, P.D.R. group), there was a record of previous psychiatric disability.

If now the percentages of patients in these last two groups (N.R.P.D. and P.D.R.) who sustained direct physical injury be compared with one another in the totals (*c*) column, it will be seen that the figure of 26·1 for the first group with no previous record of disability is higher than that of 13·9 for the second, where there was such a record. Here, so far as it goes, is an answer to the fourth question raised at the beginning of this subsection. A previous history of psychiatric disability facilitated a breakdown under a lesser degree of stress, if we are justified in assuming that the uninjured cases were subjected to less stress than the injured. The relevant difference in percentages for cases seen in 'A' type clinics (difference $=14{\cdot}7\pm4{\cdot}5$) and in 'B' type clinics (difference $=11{\cdot}9\pm5{\cdot}3$) are both significant. The difference in percentages for cases seen in the London Region is not significant.

(v) RELATION OF PREVIOUS HISTORY OF NEUROSIS TO BREAKDOWN.

It will be seen in the last column of Table XXIX that 281 out of 767 (or 36·6 per cent) psychiatric casualties associated with air raids had a previously recorded history of psychiatric disability. Owing to imperfections of the records, the figure is almost certainly an underestimate.

The percentage of persons in the general population who have histories of psychiatric disability comparable to those here recorded is not known, but it is almost certainly less than 36·6 per cent. It is more likely to be in the neighbourhood of from 10 to 15 per cent, perhaps less. It is thus probable that a previous history of psychiatric disability predisposed to breakdown under the stress of air raids.

16. Discharges from the Fighting Services.

(i) PERCENTAGES OF NEW PATIENTS.

(*a*) The questionnaire[1] asked a rather detailed question about discharges from the Fighting Services. It inquired of each case whether he or she had been discharged from the Army, the Navy or the Air Force; and it further asked that each patient should be placed in one of the following diagnostic groups depending on whether he had been discharged: (*a*) on non-psychiatric grounds; (*b*) because of neurosis; (*c*) because of mental defect; (*d*) on 'other psychiatric grounds'; (*e*) information as to grounds of discharge not available. Of these groups it may be remarked that the fourth (*d*) would include cases of psychosis.

(*b*) Of 41,982 relevant new cases, 1,185 or 2·85 per cent were recorded by clinics as having been discharged from the three Fighting Services during this war. Of these 1,185 patients, information as to the grounds

[1] See page 190.

of discharge was not available of 129. There remain 1,056 patients of whom it was known on what grounds they were discharged. The position is summarized in the following table :

TABLE XXX.—*Discharges from Fighting Services of Diagnostically Classifiable Cases in Years* 1940, 1941 *and* 1942. *Percentages of Relevant New Patients dealt with by Psychiatric Clinics situated in* (*A*) *C.B.s outside London ;* (*B*) *Administrative Counties outside London ; and* (*C*) *the London Region* (1942 *only*).

	Administrative Area.			
	A.	B.	C.	Total.
Relevant clinic years .	231	189	25	445
Total relevant new patients . .	25,976	8,989	7,017	41,982
Total Ex-service new patients . . .	589	121	346	1,056
Percentage Ex-service of total patients .	2·27	1·23	4·93	2·52

Difference between C and A = 2·66 ± 0·22.
" " A and B = 1·04 ± 0·17.

(*c*) It will be observed that the percentages vary in the three administrative areas, being highest in the London Region, where it is 4·93, next highest in the C.B.s outside London (2·27) and lowest in the small-town 'B' type clinics (1·23). How are we to account for these differences ? It is unlikely that Londoners discharged on psychiatric grounds from the Fighting Services bore a higher ratio to the population of London than did provincial psychiatric discharges to the provincial populations. The differences between London and provincial clinics in this respect are probably due to the fact that the reputation and clientele of the clinic have something to do with the number and character of the patients sent to it ; and also to the fact that good transport facilities in London make the clinics accessible. It will be seen below that the majority of psychiatric discharges from the Forces are neurotics ; such persons, finding themselves in civil life, would be more likely to be referred to a psychiatric clinic which was known to interest itself in neurosis rather than one which, rightly or wrongly, had the reputation of being a portal of entry to a Mental Hospital. It was shown in Table XXV that differences existed between the three groups of clinics (A, B and C) in the percentages of neurotics and psychotics among their total new patients.

(ii) DISTRIBUTION BY SERVICES.

(*a*) The 1056 diagnostically classifiable cases came from the three Services in the proportions shown in the following table :

TABLE XXXI.—*Discharges from Fighting Services of Diagnostically Classifiable Cases attending Psychiatric Clinics for Years* 1940, 1941 *and* 1942. *Numbers and Percentages from the Three Services.*

Discharges.	Service.			
	Army.	Navy.	R.A.F.	Total.
Numbers . . .	777	92	187	1,056
Percentages . .	73·5	8·8	17·7	100·0

These percentages can be compared with the figures kindly provided by the Ministry of Pensions for discharges on psychiatric grounds from the three Services from 3rd September 1939 to 26th December 1942. It is not yet possible to publish the numbers. The percentages are shown in the following table :

TABLE XXXII.—*Total Discharges on Psychiatric Grounds from Fighting Services between 3rd September* 1939 *and 26th December* 1942. *Percentages.*

Discharges.	Service.			
	Army.	Navy.	R.A.F.	Total.
Percentages . .	80·6	6·5	13·0	100·1

The distributions are significantly different. Proportionately more men and women discharged on psychiatric grounds from the Navy and the R.A.F. attended psychiatric clinics than did personnel discharged from the Army. I have no explanation to offer for this difference.

(iii) DISTRIBUTION BY DIAGNOSIS.

(*a*) The distribution of the 1056 diagnostically classifiable cases under their appropriate diagnoses is shown in the following table :

[TABLE XXXIII

TABLE XXXIII.—*Discharges from Fighting Services attending Psychiatric Clinics in the Years* 1940, 1941 *and* 1942 *distributed according to Service and Diagnosis. Numbers and Percentages.*

	Service.							
	Army.		Navy.		R.A.F.		Total.	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Discharged from Forces because of :								
Non-psychiatric grounds	87	11·2	10	10·9	23	12·3	120	11·4
Neurosis . . .	534	68·8	57	62·0	132	70·6	723	68·5
Mental defect. . .	36	4·6	2	2·2	6	3·3	44	4·2
Other Psychiatric grounds	120	15·5	23	25·0	26	13·9	169	16·0
Totals . .	777	100·1	92	100·1	187	100·1	1056	100·1

(*b*) It will be seen that, of the total of 1056 diagnostically classifiable cases, 723 (68·5 per cent) had been discharged because of neurosis ; 44 (4·2 per cent) because of mental defect in a broad sense ; and 169 (16·0 per cent) on other psychiatric grounds which included psychosis. The differences in the percentages contributed by the three Services to these diagnostic totals are not statistically significant.

(iv) DISTRIBUTION BY LOCATION OF CLINIC.

But there is one other difference worth mentioning which is not brought out in the above tables. The proportion of cases discharged on other psychiatric grounds, which include psychosis, seen in small-town clinics ('B' type) was significantly higher than that seen in large-town ('A' type) ; and the proportion seen in 'A' type clinics was significantly higher than that seen in the London Region. The position is shown in the following table :

TABLE XXXIV.—*Discharges from Fighting Services on 'Other Psychiatric Grounds' dealt with at Psychiatric Clinics during* 1940, 1941 *and* 1942 *in* (*A*) *C.B.s outside London,* (*B*) *Administrative Counties outside London and* (*C*) *the London Region* (1942 *only*). *Numbers and Percentages.*

	Administrative Area.			
	A.	B.	C.	Total.
Total diagnostically classifiable cases (*a*) .	589	121	346	1,056
Discharges on other psychiatric grounds (*b*)	99	33	37	169
Percentage (*b*) of (*a*) .	16·8	27·3	10·7	16·0

Difference between B and A = 10·5 ± 3·9.
" " A and C = 6·1 ± 2·4.

The difference in the percentage for small-town clinics (27·3) and for large (16·8) is significant; and so is the difference between large-town and London clinics (10·7). Of all the other diagnostic categories, the percentages seen at 'A' type clinics are higher than those of 'B' type, but the differences are not significant.

The explanation of the differences noted in Table XXXIV is again not obvious. It is perhaps on the lines already suggested in another context—that the clinic tends to get the type of patient in which it takes most interest and with which it deals best. The category 'other psychiatric grounds' comprises cases of psychosis, and it has been shown that a larger proportion of such cases are dealt with by 'B' type clinics than 'A' type.

17. Developments advocated by Directors of Psychiatric Clinics.

(i) The questionnaire asked what developments were thought desirable for psychiatric clinics by their Directors. Seven developments were listed. Of 216 clinics, views were expressed by the Directors of 169. The results are shown in the following table:

TABLE XXXV.—*Developments advocated by Directors of Psychiatric Clinics in (A) C.B.s outside London, (B) Administrative Counties outside London and (C) London Region.*

	Administrative Area.							
	A.		B.		C.		Total.	
Clinics answering .	74		65		30		169	
Developments Advocated.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Improved facilities for in-patient treatment . . .	55	74·3	40	61·5	26	86·7	121	71·6
Amplification of staff . . .	53	71·6	37	56·9	29	96·6	119	70·4
Need for services which do not exist .	42	56·8	30	46·1	23	76·7	95	56·2
Additional or larger premises . .	28	37·8	28	43·1	26	86·7	82	48·5
Better co-operation with other organizations . .	43	58·1	14	21·6	14	46·7	71	42·0
Opening new facilities in new areas .	30	40·5	24	36·9	17	56·7	71	42·0
Recall of staff from Forces . .	8	10·8	7	10·8	7	23·3	22	13·0

(ii) The developments are set out in the above table in a descending order of their popularity. They call for no particular comment beyond

that the two major deficiencies in the existing services as judged by the Directors of psychiatric clinics are the shortage of in-patient facilities and shortages of staff.

(iii) When we compare the numbers and percentages in the three administrative areas, we note that six developments out of the seven are favoured by a higher percentage of Directors of clinics in the London Region than in the County Boroughs outside London; and that much the same can be said if we compare the responses of Directors of type 'A' with type 'B' clinics. Five out of the seven developments are more favoured by the former; one by the latter and one (the last on the list) is equally supported. This result is in general accordance with expectation. Various criteria of activity have been applied in previous tables to the clinics in the three administrative groups. Judged by them all, the London clinics ('C' type) are more active than those in the County Boroughs outside London ('A' type) and the 'A' type clinics are more active than the small-town or 'B' type clinics. It is natural that there should be a keener awareness of needs and of the desirability of new developments in those clinics where activity is greatest.

18. Views of Directors upon Presence of Latent Neurosis in the Civilian Population.

(i) The questionnaire asked the Directors of clinics if, in their opinions, there existed among the civil population latent neurosis such as would be likely to disclose itself after the war. The Directors of 159 clinics gave their views, but these were often put forward with reservations and qualifications. Many held that the volume of neurosis after the war would be much affected by the social and economic conditions which then existed and the moral atmosphere which prevailed. The question was indecisively answered by 46 Directors, leaving 113 who held definite views one way or the other. The position is summarized in the following table:

TABLE XXXVI.—*Latent Neurosis in Civil Population likely to disclose itself after the War: Views of* 113 *Directors of Psychiatric Clinics in (A) C.B.s outside London, (B) Administrative Counties outside London and (C) the London Region.*

	Administrative Area.							
	A.		B.		C.		Total.	
Total answering	67		62		30		159	
Total giving definite views	50		38		25		113	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Directors believing that latent neurosis existed	34	68·0	20	52·6	11	44·0	65	57·5

(ii) The value of the above table is reduced by the large proportions of Directors who either failed to answer or who gave indefinite views. But it is perhaps worth noting that of those who gave a clear answer, more than half (57·5 per cent) believed that there existed in the civil population latent neurosis which was likely to disclose itself after the war. In view of the large numbers not answering or answering indefinitely, importance should not be attached to the varying percentages of clinics in the three administrative areas which recorded the belief that latent neurosis existed.

19. Psychiatric Clinics staffed by Psychiatrists based on Mental Hospitals ('M' Clinics) compared with Clinics otherwise staffed ('O' Clinics).

(i) NUMBERS OF CLINICS IN THE TWO CATEGORIES.

The remaining tables provide various comparisons between psychiatric clinics staffed by psychiatrists based on Mental Hospitals and those otherwise staffed. The questionnaire asked of each clinic under what auspices it had been established—*i.e.* Mental, Municipal, Voluntary Hospital, etc. Information under this heading had been provided about each clinic in a useful list previously published by the National Council for Mental Hygiene. The replies to this question about auspices were diverse and difficult to classify; but they were all reducible to the alternatives here given, where a financial question is relevant. If the Visiting Committee of a Local Authority made a contribution to the expenses, the clinic was placed in the 'M' category; for clinics thus maintained were, as far as known, always staffed by a psychiatrist based on a Mental Hospital. When the expenses of the clinic were entirely borne by the hospital, the clinic was placed in the 'O' group. There is a small number of Voluntary Hospitals whose psychiatric clinics are directed, through special arrangements, by psychiatrists prominently placed in the Mental Hospital Service. Here no contribution is made by the Local Authority, and the clinic is counted in the 'O' group. The distribution of these two categories of clinic throughout the three administrative areas considered in preceding sections is shown in the following table:

TABLE XXXVII.—*Distribution of 'M' and 'O' Clinics by Administrative Areas: (A) C.B.s outside London; (B) Administrative Counties outside London; (C) the London Region.*

	Administrative Area.			
	A.	B.	C.	Total.
'M' clinics . .	73	68	9	150
'O' clinics . .	24	9	33	66
Totals .	97	77	42	216

It will be seen that the distribution of these two types of clinic in the three administrative areas is unequal. In London there are but 9 'M' clinics; but the metropolis contains exactly half the 'O' clinics—33 out of 66. There are again but 9 'O' clinics in the small towns of 'B' type. The differences between the 'M' and 'O' clinics will therefore best be brought out if they are contrasted in their totals and not subdivided into the three administrative areas hitherto considered: and this is how the differences will be shown in the tables which follow. Indeed, the administrative area in which the clinic is located can be counted as in a way irrelevant to the point which it is sought here to establish. This point is that the type of psychiatric clinic which has mainly developed as part of the organic structure of the large London and County Borough Voluntary Hospital, or else is set up by an independent Institute, differs in certain important respects from the type of clinic of which most have been established since 1929 as a result of the Mental Treatment Act. There are certain reasons for thinking that the differences between these two categories of clinic will grow less with time. Trends should be kept under observation in future years. The matter is further discussed in Chapter IV, pages 17–21.

(ii) DATES OF FOUNDATION.

The clinics of the eleven regions have been classified in respect of the dates of their foundation in six-time-periods. For simplification these periods can be reduced to two—those before and after 1929. The Mental Treatment Act was passed in 1930, and the Local Government Act, giving major local authorities greater powers and greater interest in health, was passed in 1929. Relevant information was given by 177 clinics. The salient facts are shown in the following table:

TABLE XXXVIII.—*'M' and 'O' Clinics classified in Accordance with whether they were established before or after* 1929.

Established	Type of Clinic.					
	'M'.		'O'.		Total.	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
1929 or earlier .	13	10·3	16	31·4	29	16·4
After 1929 . .	113	89·7	35	68·6	148	83·6
Totals .	126	100·0	51	100·0	177	100·0

Difference between 'M' and 'O' = 21·1 ± 7·04.

It will be observed that, of 'M' clinics, 10·3 per cent were established before 1929, while the corresponding figure of 'O' clinics is 31·4 per cent.

(iii) ACCESSORY SERVICES.

Accessory services showed certain differences of distribution in the two categories of clinic. Information was available of 192 clinics.

TABLE XXXIX.—*Distribution of Accessory Services in 'M' and 'O' Clinics.*

	Type of Clinic.						Difference between 'M' and 'O' Clinics.
	'M'.		'O'.		Total.		
Clinics giving information .	131		61		192		
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.	
Accessory Service:							
P.S.W. . .	51	38·9	15	24·6	66	34·4	14·3±7·4
Social worker or almoner . .	36	27·5	31	50·8	67	34·9	23·3±7·4
Psychologist .	10	7·6	10	16·4	20	10·4	8·8±4·7
Speech therapist .	6	4·6	13	21·3	19	9·9	16·7±4·6

The differences in the percentages are shown in the last column. It will be seen that the 'O' clinics are better served by social workers and almoners, and also by speech therapists; they are also rather better served by psychologists, though the difference is not significant. The 'M' clinics, on the other hand, are not quite significantly better served by psychiatric social workers.

(iv) CLINIC- AND DOCTOR-SESSIONS PER WEEK.

Information as to these was provided by 189 clinics.

TABLE XL.—*Average Number of Clinic- and Doctor-Sessions per Week in 'M' and 'O' Clinics.*

	Type of Clinic.			Difference between 'M' and 'O' Clinics.
	'M'.	'O'.	Total.	
Clinics giving information . .	131	58	189	
Average number clinic-sessions per week . . .	1·07±·81	2·36±·31	1·47	1·29±·87
Average number doctor-sessions per week . .	1·54±·19	4·41±·76	2·42	2·87±·78

'O' clinics hold more frequent clinic- and doctor-sessions than 'M', the difference in respect of the former not being significant.

(v) NEW PATIENTS PER CLINIC PER YEAR.

Figures were available for 490 clinic-years and 51,601 new patients.

TABLE XLI.—*Average Number of New Patients per Clinic per Year in 'M' and 'O' Clinics.*

	Type of Clinic.		
	'M'.	'O'.	Total.
Total new patients .	27,523	24,078	51,601
Relevant clinic-years	385	105	490
Average number new patients per year per clinic . .	71·5	229·3	105·3

The difference in the average number of new patients—71·5 and 229·3—is conspicuous.

(vi) NEW PATIENTS PER SESSION.

Clinics have been grouped in six categories depending on the average number of their new patients per session. The first category comprises those clinics attended on average by under one new patient per session; the sixth those attended by five and over. Information is available of 158 clinics of which nine were on average attended by more than five new patients per session.

In the following table are distinguished clinics whereat averages of under two and of two and over new patients were received per clinic-session :

TABLE XLII.—*'M' and 'O' Clinics separated in Accordance with whether they received on Average under Two or Two and Over New Patients per Session.*

New Patients per Session.	Type of Clinic.					
	'M'.		'O'.		Total.	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Under two .	81	73·7	20	41·6	101	63·9
Two and over .	29	26·3	28	58·4	57	36·1
Totals .	110	100·0	48	100·0	158	100·0

Difference between 'M' and 'O' = 32·1 ± 8·3.

It will be seen that of known 'M' clinics, 73·7 per cent received on average under two new patients per session, while the corresponding figure for 'O' clinics—41·6 per cent—is lower. The average number of new patients per session in 'M' clinics is 1·65±·15, and in 'O' clinics 2·48±·22—a difference of ·83±·27.

(vii) RATIO OF TOTAL TO FIRST ATTENDANCES.

Another standard by which the activity of a clinic can be gauged is the ratio of total to first attendances. The matter has been discussed in paragraph 12 above (pp. 153–155).

Figures are available for 472 clinic-years covering 49,525 first, and 292,647 total, attendances.

TABLE XLIII.—*'M' and 'O' Clinics; Percentages of First among Total Attendances.*

	Type of Clinic		
	'M'.	'O'.	Total.
Clinic-years . .	379	93	472
Total attendances .	124,090	168,557	292,647
First attendances .	27,245	22,280	49,525
Percentage first of total attendances .	22·0	13·2	16·9

Difference = 8·8±0·14.

Since the total attendances comprise the first, the smaller the percentage in the bottom line, the larger the proportion of return to first attendances. The percentage of first among total attendances for 'M' clinics is 22·0; for 'O' clinics 13·2.

(viii) RATIO OF TOTAL TO FIRST ATTENDANCES; CLINICS WITH DIFFERENT RATIOS IN THE TWO GROUPS COMPARED.

In Table XX above was shown a distribution of clinics in respect of the ratio of their total attendances to their new patients. A similar comparison between 'M' and 'O' clinics is shown in the following table:

[TABLE XLIV

TABLE XLIV.—*'M' and 'O' Clinics compared in Respect of Ratio between Total and First Attendances.*

	Type of Clinic.					
	'M'.		'O'.		Total.	
Clinics: numbers . .	108		45		153	
	No.	Per Cent.	No.	Per Cent.	No.	Per Cent.
Clinics where total÷first attendances is: .						
(*a*) Under two . .	26	24·1	2	4·4	28	18·3
(*b*) Under three .	51	47·2	5	11·1	56	36·6
(*c*) Three and over .	57	52·8	40	88·9	97	63·4
Totals: (*b*)÷(*c*) .	108	100·0	45	100·0	153	100·0

Difference for (*a*) = 19·7 ± 6·9.
" " (*b*) = 36·1 ± 8·5.

It will be observed that of 'M' clinics, those whose total attendances were less than three times their first (which means that they dealt with less than two return attendances to every new patient), amounted to 47·2 per cent, while the corresponding figure for 'O' clinics (11·1 per cent) is lower. The ratio for clinics whose total attendances were less than twice their first is 24·1 per cent ('M' clinics) to 4·4 per cent ('O' clinics).

(ix) NEW PATIENTS PER DOCTOR-SESSION.

This matter was discussed on pages 151–152, where it was stressed that the number of new patients per doctor-session reflected not so much on the activity of a clinic as on its organization. A well-organized clinic using an appointment system would feed new and old patients to the medical staff at their doctor-sessions so as to make best use of their time; they would not ask their doctors to see more patients at a session than they could deal with efficiently and without haste. Too high a figure of new patients per doctor-session implies not that the clinic is active but that it is unduly pressed; and it implies that the organization of the clinic needs overhauling.

Here are the ratios for 'M' and 'O' clinics:

[TABLE XLV

TABLE XLV.—*'M' and 'O' Clinics; New Patients per Doctor-Session.*

	Type of Clinic.		
	'M'.	'O'.	Total.
Clinic-years . . .	377	103	480
Total new patients .	26,838	23,978	50,816
Total doctor-sessions .	31,407	21,070	52,477
New patients per doctor-session . . .	0·85	1·14	0·97

It will be observed that, at the average 'M' clinic, there were seen 0·85 new patients per doctor-session, while the corresponding figure or 'O' clinics is 1·14. Neither figure suggests that the *average* known clinic is either very active or unduly pressed. But there are the usual variations from region to region and still greater variations from clinic to clinic; these variations reflect the need for careful organization and for greater elasticity when the need for expansion is apparent.

(x) INCIDENCE OF NEUROSIS AND PSYCHOSIS AMONG NEW PATIENTS.

This subject was discussed in paragraph 14 above.

TABLE XLVI.—*'M' and 'O' Clinics: Percentages of Neurotics and Psychotics among Relevant New Patients.*

	Type of Clinic.		
	'M'.	'O'.	Total.
Clinic-years . . .	351	97	448
(*a*) Total relevant new patients . . .	24,506	20,695	45,201
(*b*) Neurotic new patients .	10,962	12,969	23,931
(*c*) Percentage (*b*) of (*a*) .	44·7	61·9	52·9
(*d*) Psychotic new patients	8,668	4,171	12,839
(*e*) Percentage (*d*) of (*a*) .	35·4	20·2	28·4

(*c*) Difference = 17·2 ± 0·49.
(*e*) ,, = 15·2 ± 0·43.

It will be observed that of 'M' clinics, 44·7 per cent of new patients were recorded as neurotic, while the corresponding figure for 'O'

clinics—61·9—is significantly higher. An inverse incidence is seen in the figures for psychosis, the percentage being 35·5 for 'M' and 20·2 for 'O' clinics.

(xi) SUMMARY.

Summarizing the findings of the last ten tables, it may be generally said that 'M' group clinics showed the following differences from 'O': they were established later; they were less well equipped with social workers, almoners, psychologists [1] and speech therapists, but better equipped with psychiatric social workers [1]; they held less frequent clinic- [1] and doctor-sessions; they dealt with fewer new patients per year and with fewer at the average clinic- and doctor-session; they saw fewer return cases; and they dealt with a smaller proportion of neurotics and a larger one of psychotics.

These findings are not to be counted in disparagement of the work done by Local Authorities. On the contrary, these deserve credit for notable achievements (see pp. 18–20).

[1] Differences not quite significant.

APPENDIX I

Questionnaire used in the Neurosis Survey

MINISTRY OF HEALTH

NEUROSIS SURVEY: PART I

Where one of two questions Yes : No *is asked, kindly encircle appropriate reply.*

(1) Name and address of Clinic ? (Kindly specify institution, if any, in which it is housed.)

(2) Under whose auspices is the Clinic established ? (*i.e.*, Mental Hospital, Municipal or Voluntary Hospital, etc.).

(3) When was the Clinic established ?

(4) (See Notes) [1] Name(s) of psychiatrist(s) on staff ?
(If more than one, please star senior psychiatrist ; also mention those temporarily absent owing to the war.)

(5) (*a*) (See Notes) [1] Does more than one psychiatrist generally attend at each session ? Yes : No

(*b*) If yes, how many attend ?

(6) Does the staff of your clinic include the undermentioned (Table I) :

TABLE I. ACCESSORY SERVICES

Accessory Services.		If Yes :—	
		On what basis of time ?	Where trained ? (Please give qualifications, if any)
(1) A non-medical psychologist .	Yes : No		
(2) A social worker . . .	Yes : No		
(3) A psychiatric social worker .	Yes : No		
(4) A speech therapist . .	Yes : No		

(7) Can you get, when desired (Table II) :

TABLE II. ACCESSORY SERVICES

		If yes, where and by whom ?
(1) Pathological examinations .	Yes : No	
(2) Further physical * examination and advice . . .	Yes : No	

* Please state if you have difficulties over any special examinations—*e.g.* E.N.T., Eyes, Gynaecology, Radiography, etc.

[1] Refers to a leaflet of notes and instructions which accompanied the questionnaire. Not here reproduced.

(8) (*a*) When are sessions held ?
(Please give days and times.)

(*b*) What is the average duration of each session ?

(9) (*a*) Are children (sixteen and under) treated ? Yes : No

(*b*) If yes, are they seen at special children's sessions ? Yes : No

(*c*) If yes, when are these sessions held ?
(Please give days and times if not already given.)

(10) (See Note) [1] Do the psychiatrists on the staff of your clinic do psychotherapy ? Yes : No

If yes, is this done by any special member of the staff, or is it undertaken by all members ?

Have you a visiting or consultant psychotherapist ?

If yes, on what basis of time ?

(11) (*a*) During the war years, has the pressure on your clinic ever been such as to necessitate a refusal to treat patients ? Yes : No

(*b*) If yes, kindly give particulars.

[1] Refers to a leaflet of notes and instructions which accompanied the questionnaire. Not here reproduced.

MINISTRY OF HEALTH

NEUROSIS SURVEY : PART II

Name of Clinic.....

Where one of two questions Yes : No *is asked, kindly encircle appropriate reply.*

(12) (See Note)[1] Kindly give following particulars (Table III) :

TABLE III. ATTENDANCES AT CLINICS, 1938, 1940, 1941 AND 1942

		Attendances.	1938.*	1940.	1941.	1942.
Adults only (over sixteen)	*a*	Total new patients				
	b	Average number of 'New' patients per session				
	c	Total patients (new and old) . .				
	d	Total attendances, new and old (includes return cases)				
	e	Average attendance per session (new and old : includes return cases) . .				
Children sixteen and under	*f*	Average number of 'New' children per session				
	g	Average total attendance per session of children (new and old : includes return cases)				

* Figures for 1938 and not 1939 are asked for, because 1939 was representative neither of peace-time nor of war-time conditions.

(13) (*a*) (See Note)[1] In the course of 1939–42 inclusive, were any of your patients[2] admitted to hospital beds for psychiatric treatment ? Yes : No

(*b*) If yes, please give following particulars (Table IV) :

TABLE IV. REFERRAL OF ADULT NEW CASES AS PSYCHIATRIC IN-PATIENTS TO MENTAL AND NON-MENTAL HOSPITALS—1938, 1940, 1941 AND 1942 (either direct or via Relieving Officer or other intermediary)

NAME OF HOSPITAL.	No. of Admissions in											
	1938.			1940.			1941.			1942.		
	V.	T. & C.	O.	V.	T. & C.	O.	V.	T. & C.	O.	V.	T. & C.	O.

V. = Voluntary patient. T. & C. = Temporary and Certified Cases. O. = Other patients.

[1] Refers to a leaflet of notes and instructions which accompanied the questionnaire. Not here reproduced.

[2] Includes Voluntary, Temporary and certified patients.

(14) (See Notes)[1] Kindly give following particulars (Table V):

TABLE V. DIAGNOSES (NEW CASES: ADULTS ONLY, 1938, 1940, 1941 AND 1942)

Diagnosis.	1938.	1940.	1941.	1942.
Psychoneurosis				
Psychosis				
Other				
Total . . .				

(15) (See Notes)[1] Please classify your *new* cases according to the following *sources* (Table VI):

TABLE VI. SOURCES OF NEW PATIENTS (ADULTS ONLY: 1938, 1940, 1941 AND 1942)

Source.	Number of New Cases in			
	1938.	1940.	1941.	1942.
From Mental Hospitals as discharged patients .				
From Non-Mental Hospitals				
From Private Doctors				
From Medical Officers of the Armed Forces .				
From Factory Doctors				
From Probation Officers				
From Observation Wards or Relieving Officer .				
From Non-Medical Social and Welfare Organizations *				
Attended on their own; no introductory letter .				
From other sources *				
Information not available from Records . .				
Total . . .				

* Please specify which.

(16) (See Notes)[1] Please classify your *new* cases according to the following methods of *disposal* (Table VII):

[1] Refers to a leaflet of notes and instructions which accompanied the questionnaire. Not here reproduced.

TABLE VII. DISPOSAL OF NEW PATIENTS (ADULTS ONLY: 1938, 1940, 1941 AND 1942)

(Please do not enter more than one mode of disposal for any one patient)

	Modes of Disposal.	Number disposed of in			
		1938.	1940.	1941.	1942.
a	To Mental Hospital direct as voluntary temporary or certified patients . . .				
b	To Observation Ward, Relieving Officer or other intermediary with a view to certification				
c	To Non-Mental Hospitals				
d	To Convalescent or Nursing Homes . .				
e	Report to Hospital Consultant or Private Doctor when patient is not sent to Hospital or Home				
f	Report to Non-Medical (Social) Welfare or After-care Organization *				
g	Advice to Patient or relatives when no letter or report is sent about patient . .				
h	Other method †				
i	Information not available on Records .				
j	Total				

* Please specify which.

† Please specify which, and include cases referred to Mental Deficiency Act Committee, or local Mental Welfare Associations.

MINISTRY OF HEALTH.

NEUROSIS SURVEY : PART III

Name of Clinic .....

Where one of two questions Yes : No *is asked, kindly encircle appropriate reply.*

(17) (*a*) Has the area from which your Clinic draws its patients suffered from air raids ? Yes : No

(*b*) Has this area received patients evacuated from other areas subjected to air raids ? Yes : No

(*c*) If the answer to (*a*) is yes, has your Clinic received psychiatric cases associated with such raids ? Please describe approximately the frequency and severity of the raids.

(*d*) If the answer to (*a*) or (*b*) is yes, kindly give following particulars (Tables VIII and IX) :

TABLE VIII. DISPOSAL OF PSYCHIATRIC CASES (ADULTS ONLY) ASSOCIATED WITH AIR RAIDS

(M = Males. F = Females.)

Disposal.	1940.		1941.		1942.	
	M.	F.	M.	F.	M.	F.
Treated as out-patients and not referred to hospital for admission						
Referred to hospital (of any description) for admission because of psychiatric disability associated with air raids.						

TABLE IX. PSYCHIATRIC CASUALTIES ASSOCIATED WITH AIR RAIDS 1940–42 INCLUSIVE (ADULTS ONLY)—*See note* [1]

	Males.	Females.
No recorded psychiatric disability before 1940 : (*a*) Those who sustained direct physical injury during air raids .		
(*b*) Those who did not sustain direct physical injury . .		
Psychiatric disability before 1940 recorded : (*a*) Those who sustained direct physical injury during air raid .		
(*b*) Those who did not sustain direct physical injury . .		
Previous psychiatric condition not recorded : (*a*) Those who sustained direct physical injury during air raid .		
(*b*) Those who did not sustain direct physical injury . .		

[1] Refers to a leaflet of notes and instructions which accompanied the questionnaire. Not here reproduced.

(18) (*a*) Has your Clinic dealt with men or women who have been discharged from the Fighting Services during this war on psychiatric or other grounds ? Yes : No

(*b*) If *yes* please give the following particulars (Table X) :

TABLE X. 'NEW' PATIENTS ALREADY DISCHARGED FROM THE FIGHTING SERVICES 1940–42—*See note*[1]

(M = Males. F = Females)

		Discharges from the Fighting Services.	1940.		1941.		1942.		Total.	
			M.	F.	M.	F.	M.	F.	M.	F.
ARMY.		*a* On non-psychiatric grounds .								
	Psychiatric grounds.	*b* Neurosis								
		c Mental Defect *								
		d Other psychiatric grounds .								
		e Information not available .								
NAVY.		*a* On non-psychiatric grounds .								
	Psychiatric grounds.	*b* Neurosis								
		c Mental Defect *								
		d Other psychiatric grounds .								
		e Information not available .								
R.A.F.		*a* Non-psychiatric grounds . .								
	Psychiatric grounds.	*b* Neurosis								
		c Mental Defect *								
		d Other psychiatric grounds .								
		e Information not available .								

* Include dull and backward.

[1] Refers to a leaflet of notes and instructions which accompanied the questionnaire. Not here reproduced.

MINISTRY OF HEALTH

NEUROSIS SURVEY: PART IV

Name of Clinic.....

Where one of two questions Yes : No *is asked, kindly encircle appropriate reply.*

(19) Are there any developments under the following headings which appear to you to be necessary to meet changing local requirements, including industrial or war needs ?

(*a*) Amplification of medical or non-medical staff ?
(Would your clinic be helped by a psychiatric social worker if it has not got one ?) — Yes : No *

(*b*) Recall of staff from Services ? — Yes : No *

(*c*) Additional or larger premises ? — Yes : No *

(*d*) Improved facilities for In-patient treatment of neurotics ? — Yes : No *

(*e*) Need for services which do not yet exist ? † — Yes : No *

(*f*) Better co-operation with other existing facilities or organisations ? † — Yes : No *

(*g*) Opening new facilities in new areas ? — Yes : No *

* If yes, please give particulars below against appropriate headings.
† *E.g.* Rehabilitation, Diagnostic, Therapeutic Services, etc.

(20) What are your views as to how mental illness in your region could be prevented ? How far could this be done in industry and large-scale occupations by more careful selection, more discriminating employment and better management ?

(21) Is there, in your opinion, much latent or hidden neurosis which may disclose itself after the war ?

(22) Any other suggestions, opinions or comments ?

APPENDIX II

ELEVEN CIVIL DEFENCE REGIONS:
CONSTITUENT COUNTIES AND AUTHORITIES

Region.	
I	Northumberland, Durham, Yorkshire (North Riding).
II	East and West Riding of Yorkshire.
III	Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire, Rutland, Soke of Peterborough.
IV	Bedford, Cambridge, Huntingdon, Norfolk, Suffolk, E. and W., Isle of Ely, Essex,* Hertford.*
V	Counties of London and Middlesex. Part of County of Essex (*i.e.* East Ham C.B., West Ham C.B., Barking B., Chingford B., Dagenham B., Ilford B., Leyton B., Wanstead and Woodford B., Walthamstow B., Chigwell U.D., Waltham Holy Cross U.D. Part of County of Kent (*i.e.* Beckenham B., Bexley B., Bromley B., Erith B., Chislehurst and Sidcup U.D., Crayford U.D., Orpington U.D., Penge U.D.). Part of County of Surrey (*i.e.* Croydon C.B., Barnes B., Beddington and Wallington B., Epsom and Ewell B., Kingston-on-Thames B., Malden and Coombe B., Mitcham B., Richmond B., Surbiton B., Sutton and Cheam B., Wimbledon B., Banstead U.D., Carshalton U.D., Coulsdon and Purley U.D., Esher U.D., Merton and Morden U.D.). Part of County of Herts (*i.e.* Barnet U.D., Bushey U.D., Cheshunt U.D., East Barnet U.D., Barnet R.D., Parish of Aldenham in Watford R.D.).
VI	Berks, Bucks, Dorset, Hants, Oxfordshire, Isle of Wight.
VII	Cornwall, Devon, Gloucester, Somerset, Wilts.
VIII	Wales and Monmouth.
IX	Hereford, Shropshire, Staffs, Warwick, Worcester.
X	Cheshire, Cumberland, Lancashire, Westmorland.
XII	Kent,* Sussex, East and West, Surrey.*

* Less the portion in No. V. Region.

APPENDIX III

ELEVEN CIVIL DEFENCE REGIONS:
POPULATIONS AVERAGED OVER THE FOUR YEARS 1938, 1940, 1941 AND 1942

A = County Boroughs outside London Region.
B = All other administrative areas outside London Region.
C = The London Region (V).

Region I .	A. 971,085 B. 1,583,412	Totals = 2,554,497	
,, II .	A. 2,144,282 B. 1,683,265	Totals = 3,827,547	
,, III .	A. 910,497 B. 2,229,705	Totals = 3,140,202	
,, IV .	A. 334,985 B. 2,351,453	Totals = 2,686,438	
,, VI .	A. 680,490 B. 1,660,792	Totals = 2,341,282	
,, VII .	A. 775,533 B. 2,050,532	Totals = 2,826,065	
,, VIII .	A. 527,625 B. 2,004,600	Totals = 2,532,225	
,, IX .	A. 2,023,932 B. 1,947,810	Totals = 3,971,742	
,, X .	A. 3,344,845 B. 2,932,685	Totals = 6,277,530	
,, XII .	A. 250,647 B. 1,937,460	Totals = 2,188,107	
Totals .	A. 11,963,921 B. 20,381,714	Totals = 32,345,635	
	C. London Region (V)	7,232,611	
	Total, A, B and C	= 39,578,246	

APPENDIX IV

Regional Investigators

Region.	Regional Investigators (Triumvirs).		
	E.M.S. Representatives.	Board of Control Representatives.	Army Representatives.
I	T. A. Munro, Esq., M.D., F.R.C.P.(Ed.).	H. D. MacPhail, Esq., O.B.E., M.D. (convener).	Lt.-Col. R. F. Tredgold, B.A., M.D. Lt.-Col. J. D. W. Pearce, M.D., F.R.C.P.(Ed.), D.P.M.
II	E. Fretson-Skinner, Esq., M.D., F.R.C.P.	T. M. Davie, Esq., M.C., M.D., D.P.M. (convener).	Lt.-Col. R. F. Tredgold, B.A., M.D. Lt.-Col. J. D. W. Pearce, M.D., F.R.C.P.(Ed.), D.P.M.
III	E. Fretson-Skinner, Esq., M.D., F.R.C.P.	T. W. Davidson, Esq., M.B., Ch.B., D.P.M. (convener).	Lt.-Col. R. F. Tredgold, B.A., M.D. Lt.-Col. J. D. W. Pearce, M.D., F.R.C.P.(Ed.), D.P.M.
IV	Hon. W. S. Maclay, O.B.E., M.D., M.R.C.P., D.P.M. (convener).	W. J. T. Kimber, Esq., M.R.C.S., L.R.C.P., D.P.M.	Lt.-Col. L. F. Browne, M.D. Major D. Carroll, M.A., M.R.C.S., L.R.C.P.
V	Aubrey J. Lewis, Esq., M.D., F.R.C.P. (convener).	J. S. Harris, Esq., M.D., M.R.C.P., D.P.M.	Lt.-Col. L. F. Browne, M.D. Major D. C. Carroll, M.A., M.R.C.S., L.R.C.P.
VI	L. Minski, Esq., M.D., F.R.C.P.	J. S. I. Skottowe, Esq., M.D., D.P.M.	Lt.-Col. G. S. Nightingale, M.R.C.S., L.R.C.P., D.P.M.
VII	H. H. Carleton, Esq., M.D., F.R.C.P.	S. M. Allen, Esq., M.D., D.P.M.	Major J. P. Spillane, M.B., D.P.M. (convener).
VIII	W. C. M. Scott, Esq., M.D. D.P.M. (convener).	S. Davies, Esq., M.B., B.S., D.P.M.	Major N. Copeland, M.B., D.P.M. Lt.-Col. J. D. W. Pearce, M.D., F.R.C.P.(Ed.), D.P.M.
IX	C. L. C. Burns, Esq., M.R.C.S., L.R.C.P., D.P.M. Prof. P. C. P. Cloake, M.D., F.R.C.P.	A. Shepherd, Esq., M.D., D.P.M. (convener).	Major N. Copeland, M.B., D.P.M. Lt.-Col. J. D. W. Pearce, M.D., F.R.C.P.(Ed.), D.P.M. Major F. E. Pilkington, M.A., M.R.C.P., D.P.M.
X	W. Johnson, Esq., M.C., M.D., F.R.C.P. (convener).	J. Silverstone, Esq., M.B., B.S.	Major N. Copeland, M.B., D.P.M. Lt.-Col. J. D. W. Pearce, M.D., F.R.C.P.(Ed.), D.P.M.
XII	L. Minski, Esq., M.D., F.R.C.P. (convener).	W. McCartan, Esq., M.D., M.R.C.P., D.P.M.	Lt.-Col. G. S. Nightingale, M.R.C.S., L.R.C.P., D.P.M.

APPENDIX V

Out-Patient Clinics in England and Wales

Region I.

Mental Clinic, Royal Victoria Infirmary, Newcastle-on-Tyne.
Gateshead Psychiatric Out-patients' Clinic, Royal Victoria Infirmary, Newcastle-on-Tyne.
Durham County Mental Hospital, Psychiatric Clinic, Greenbank Hospital, Darlington.
E.M.S. Hospital, Hemlington, Middlesbrough.
Out-patient Psychiatric Clinic, Cottage Hospital, Morpeth, Northumberland.
Psychiatric Clinic, Durham County Hospital.
Scarborough General Hospital.
Royal Infirmary, Sunderland.
Mental Welfare Association, 7 Murton Street, Sunderland.
St. Luke's Hospital, Middlesbrough.

Region II.

Wakefield Mental Hospital Clinic, Wakefield Mental Hospital.
Psychiatric Clinic, Clayton General Hospital, Wakefield.
Psychological Clinic, General Infirmary, Leeds.
Psychotherapeutic Clinic, Royal Infirmary, Huddersfield.
Neurological Clinic, Dewsbury and District General Infirmary, Dewsbury.
Psychotherapeutic Clinic, Beckett Hospital, Barnsley.
Psychotherapeutic Clinic, General Infirmary, Halifax.
Hull Royal Infirmary.
Psychiatric Clinic, Royal Infirmary, Bradford.
Out-patient Clinic, Middlewood Hospital, West Riding Mental Hospital, Sheffield.
Wadsley Mental Hospital (Clinic held at Sheffield Royal Infirmary).
Clinic for Nervous Diseases, Rotherham Municipal General Hospital.
Neuro-psychological Clinic, Royal Infirmary, Sheffield.
Neuro-psychological Clinic, Royal Hospital, Sheffield.
East Riding Mental Hospital, Beverley.
Harrogate and District General Hospital.
Storthes Hall Mental Hospital, Kirkburton, near Huddersfield.
Doncaster Royal Infirmary.
Harrogate General Infirmary.
County Hospital, York.
North Riding Mental Hospital, Clifton, York.
West Riding Mental Hospital, Menston, Leeds.

Region III.

Tower House Out-patient Clinic, Victoria Road, Leicester.
Francis Dixon Lodge Out-patient Clinic, City Mental Hospital, Humberstone, Leicester.
Psychotherapeutic Clinic, Leicester Royal Infirmary.
General Hospital, Northampton.
Nerve Clinic, General Hospital, Nottingham.
Nerve Clinic, St. Anne's Hospital, Thorneywood, Nottingham.
Psychiatric Clinic, Chesterfield and N. Derbyshire Royal Hospital.
Memorial Hospital, Peterborough.

Beaconsfield C. C. Building, Grantham.
Stamford and Rutland Infirmary, Stamford.
Psychiatric Clinic, Derbyshire Royal Infirmary (Borough Patients).
Psychiatric Clinic, Derbyshire Royal Infirmary (County Patients).
Grimsby and District Hospital, Grimsby.
County Hospital, Lincoln.

Region IV.

Psychiatric Clinic, Southend General Hospital, Southend-on-Sea.
Psychological Clinic, East Suffolk and Ipswich Hospital.
Psychiatric Clinic, Norfolk and Norwich Hospital.
County Psychological Clinic, Norfolk and Norwich Hospital.
Psychiatric Department and Child Guidance Clinic, Addenbrooke's Hospital, Cambridge.
Psychological Clinic, Luton and Dunstable Hospital.
Clinic for Mental and Nervous Diseases, Oldchurch Hospital, Romford, Essex.
Psychiatric Clinic, Essex and Chelmsford Hospital.
Psychiatric Clinic, Essex County Hospital.
Psychiatric and Child Guidance Service, Hill End, St. Albans.
Psychiatric Clinic, Bedford County Hospital, Annexe, Bedford.
Hitchin Hospital, Hitchin, Herts (transferred to Three Counties Hospital, Arlesey, Beds, in 1940).
Public Health Centre, Huntingdon.
Haymeads Emergency Hospital, Bishop's Stortford.

Region V.

London Hospital, Whitechapel, E.1.
Mile End Hospital, Bancroft Road, E.1.
Psychiatric Clinic, East Ham Memorial Hospital, Shrewsbury Road, E.7.
Queen Mary's Hospital, Psychiatric Clinic, Stratford, E.15.
Psychiatric Clinic, Connaught Hospital, Walthamstow.
Invalid Crippled Children's Hospital, Psychiatric Clinic, Plaistow, E.13.
St. Bartholomew's Hospital, E.C.1.
Psychiatric Clinic, St. Mary's Hospital, Highgate Hill, N.19.
Elizabeth Garrett Anderson Hospital, N.W.1.
Royal Northern Hospital, Neurological Clinic, Holloway Road, N.7.
Redhill County Hospital, Psychiatric Clinic, Edgware.
Charing Cross Hospital, Agar Street, W.C.
Department of Psychological Medicine, University College Hospital, W.C.
British Hospital for Functional Mental and Nervous Disorders, 72 Camden Road, N.W.
Tavistock Clinic, Kidderpore Avenue, N.W.
National Hospital, Queen Square.
Maida Vale Hospital for Nervous Diseases, W.9.
West End Hospital for Nervous Diseases, Welbeck Street, W.
London Clinic of Psycho-Analysis, 96 Gloucester Place, W.
Institute for the Scientific Treatment of Delinquency, 17 Manchester Street, W.1.
St. Marylebone and Western General Dispensary, 48 Cosway Street, N.W.1.
Central Middlesex County Hospital, Acton Lane, Willesden.
Department of Psychological Medicine, Middlesex Hospital, W.1.
Psychiatric Department, St. Mary's Hospital, Paddington, W.2.
Psychiatric Clinic, St. Charles' Hospital, Ladbroke Grove, W.10.
St. George's Hospital, Psychiatric Clinic, Hyde Park Corner, S.W.1.

Psychiatric Department, West London Hospital, Hammersmith, W.
Psychiatric Department, West Middlesex Hospital, Isleworth.
Westminster Hospital, S.W.1.
St. John's Hospital, St. John's Hill, Battersea.
St. Thomas's Hospital, S.E.1.
Psychiatric Clinic, Redhill County Hospital, Surrey.
Psychiatric Clinic, Kingston County Hospital, Kingston-on-Thames.
Maudsley Hospital, Out-patient Department, Denmark Hill, S.E.5.
Croydon Corporation, Mental Health Clinic, 13 Katharine Street, Croydon.
Croydon Corporation, Mental Health Clinic, Mayday Hospital.
Croydon Corporation, Mental Health Clinic, Croydon General Hospital.
Department of Psychological Medicine, Croydon General Hospital.
Miller General Hospital, Psychiatric Clinic, Greenwich High Road, S.E. (discontinued at present).
St. John's Hospital, Morden Hill, Lewisham.
Department of Psychological Medicine, Guy's Hospital, S.E.
Farnborough Hospital, Kent.

Region VI.

Psychiatric Clinic, Royal Berks Hospital, Reading.
Out-patient Clinic for Nervous Diseases, Radcliffe Infirmary, Oxford.
Clinic for Nervous and Mental Disorders, St. James' Hospital, Portsmouth.
Psychiatric Clinic, Royal Victoria and West Hants Hospital, Boscombe, Hants.
Psychological Clinic, Ravenswood House, Fareham, Hants.
Psychological Clinic, Royal Hampshire County Hospital, Winchester.
Mental Welfare Clinic, Northwood House, Cowes, I.O.W.
Mental Welfare Clinic, Whitecroft, Newport, I.O.W.
Mental Welfare Clinic, County Hall, Newport, I.O.W.
Mental Welfare Clinic, Nurses' Institute, Freshwater, I.O.W.
Mental Welfare Clinic, Royal I.O.W. County Hospital, Ryde, I.O.W.
King Edward VII Hospital, Windsor, Berks.
Berkshire Mental Hospital, near Wallingford.
Newbury Psychiatric Clinic, Greenham House, Newbury, Berks.
Royal Bucks Hospital, Aylesbury.
Out-patient Department, Cornelia and East Dorset Hospital, Poole.
Psychiatric Clinic, County Hospital, Dorchester.
Weymouth and District Hospital.
Municipal Clinic, Southampton.

Region VII.

Burden Neurological Institute, Stoke Lane, Stapleton, Bristol.
Psychological Medicine Clinic, Bristol Royal Infirmary.
Gloucester Neurological Clinic, Gloucester Royal Infirmary.
Royal Devon and Exeter Hospital.
Out-patient Clinic for Nervous Diseases, Pilton House, Richmond Road, Exeter.
Bristol Mental Hospital, at 12 Grove Road, Redland, Bristol.
Devon Mental Hospital, at Queen Street Dispensary, Exeter.
Neurological Clinic, Prince of Wales Hospital, Greenbank, Plymouth.
Royal Cornwall Infirmary, Truro.
Shepton Mallet and District Hospital Clinic.
Out-patient Clinic, Bridgewater Health Centre, Mount Street, Bridgwater.
Out-patient Clinic, Taunton and Somerset Hospital, Taunton.

Neurological and Psychiatric Clinic, Trowbridge and District Hospital, Trowbridge.
Neurological and Psychiatric Clinic, Victoria Hospital, Swindon.
Queen Alexandra Memorial Hospital, Weston-super-Mare.
Bristol General Hospital.
Royal United Hospital, Bath.
Bath: Weston Lodge.

Region VIII.

Psychiatric Out-patient Department, Cardiff Royal Infirmary.
Psychiatric Clinic, Royal Gwent Hospital, Newport, Mon.
Swansea General and Eye Hospital.
The Clinic, Ynysangharad Park, Pontypridd, Glam.
Council Offices, 8 Wina Street, Neath.
School Clinic, Quarella Road, Bridgend.
Bangor Clinic, Caernarvon and Anglesey Infirmary, Bangor.
Mold Clinic, Mold, Flintshire.
Wrexham Clinic, 23 Grosvenor Road, Wrexham.
Colwyn Bay Clinic, Nant-y-Glyn Road, Colwyn Bay.
Dolgelly Clinic, Dolgelly, Merionethshire.
General Hospital, Llanelly.
Pembroke County War Memorial Hospital, Haverfordwest.
County Infirmary, Carmarthen.
Cardigan and District Memorial Hospital, Cardigan.
Cardiganshire General Hospital, Aberystwyth.

Region IX.

North Staffs Royal Infirmary.
Psychiatric Clinic, General Hospital, Walsall.
Psychological Medicine, Selly Oak Hospital, Selly Oak, Birmingham.
Midland Nerve Hospital, Psychological Department, Bath Road, Birmingham.
Dept. of Psychological Clinic, General Hospital, Birmingham.
City of Birmingham, Psychological Clinic (Winson Green Division). Held at Dudley Road Municipal Hospital, Birmingham.
Coventry and Warwickshire Hospital, Coventry.
Worcester Royal Infirmary, Psychological Clinic.
Psychiatric Clinic, Royal Infirmary, Worcester.
Psychological Clinic, Herefordshire General Hospital, Hereford.
Warneford Hospital, Leamington Spa.
Hospital of St. Cross, Rugby.
Shropshire Mental Treatment Clinic, Royal Salop Infirmary, Shrewsbury.
Psychological Clinic, Corbett Hospital, Stourbridge.
General Infirmary, Burton-on-Trent.
General Infirmary, Stafford.
W. Bromwich and District General Hospital.
Royal Hospital, Wolverhampton.

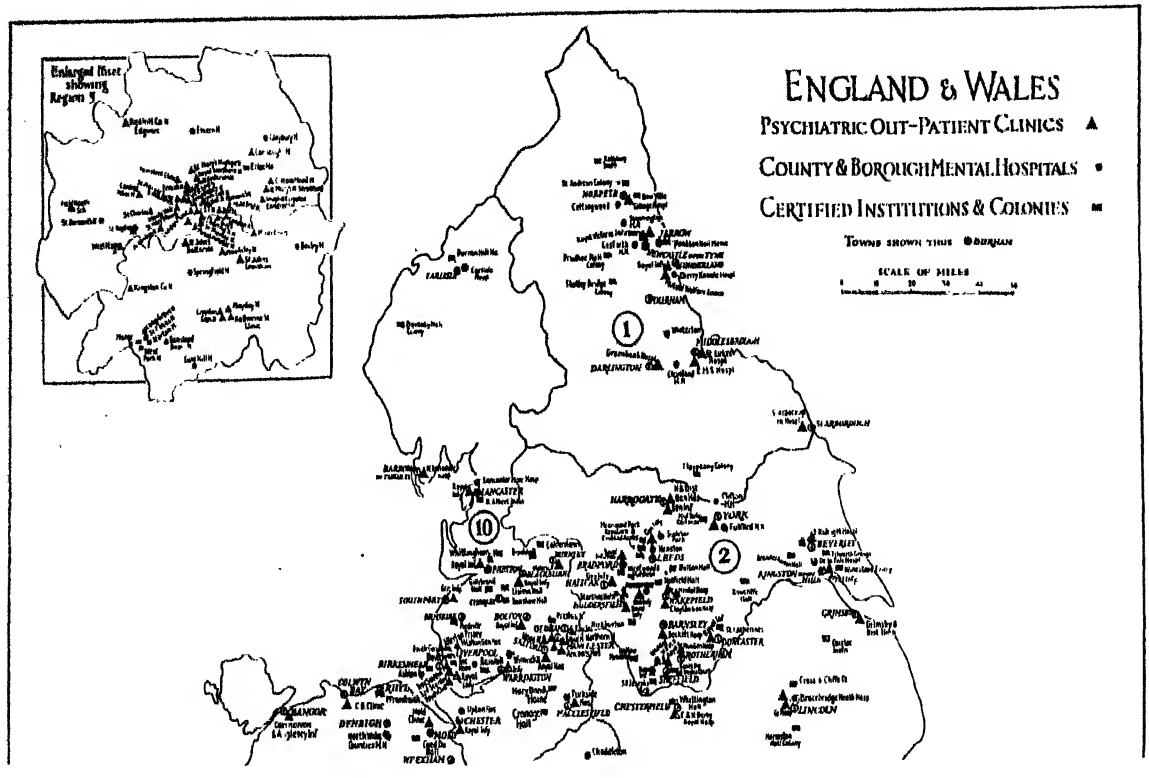
Region X.

Department of Psychological Medicine, Royal Infirmary, Liverpool.
Royal Southern Hospital, Liverpool.
Psychotherapeutic Clinic, Liverpool and Stanley Hospital.
Liverpool Psychiatric Clinic, 1 Abercromby Square, Liverpool 7.
Psychiatric Clinic, Walton General Hospital, Liverpool.
Psychotherapeutic Clinic, Bootle General Hospital.
The Special Clinic, Salford Hope Hospital.

Psychological Clinic, Salford Royal Hospital.
Psychiatric Clinic, Neurological Department, Manchester Royal Infirmary.
Psycho-Neurological Department, Manchester Northern Hospital, Cheetham Hill Roa , Manchester.
Ancoats Hospital, Mill Street, Manchester.
Mental Treatment Clinic, S.E. Lancs Mental Welfare Association, 9 Anson Road, Manchester.
Psychiatric Clinic, Chester Royal Infirmary, Chester.
Voluntary Mental Clinic, Preston and County of Lancaster Royal Infirmary, Preston.
Mental Clinic, Victoria Hospital, Burnley.
Clinic for Mental and Nervous Diseases, Royal Infirmary, Bolton.
Neurological Clinic, Blackburn and East Lancashire Royal Infirmary, Blackburn.
Nerve Clinic, North Lonsdale Hospital, Barrow-in-Furness.
Mental Treatment Clinic, Royal Infirmary, Oldham.
Neurological Clinic, Warrington Infirmary.
Psychological Clinic, Southport General Infirmary, Southport.
Royal Lancaster Infirmary Nerve Clinic, Royal Infirmary, Lancaster.
Parkside Clinic, Macclesfield.

Region XII.

Early Nervous Disorders Clinic, Municipal Hospital, Brighton.
Guardianship Society, 3 Buckingham Place, Brighton.
Clinic for Nervous Disorders, Royal Sussex County Hospital, Brighton.
Royal East Sussex Hospital, Hastings.
Kent Clinics for Nervous Disorders, Kent and Canterbury Hospital, Canterbury.
Royal West Sussex Hospital, Chichester.
E. Sussex Clinics for Nervous Disorders, Princess Alice Hospital, Eastbourne.
Lady Chichester Hospital, Out-patient Department, New Church Road, Hove.
Hove Clinic, Hove Hospital, Sackville Road, Hove.
E. Sussex Clinic for Nervous Disorders, Victoria Hospital, Lewes.
Worthing Hospital.
West Kent General Hospital, Maidstone.
County Hospital, Farnborough, Kent.
Psychological Clinic, County Hospital, Dartford.
Kent and Sussex General Hospital, Tunbridge Wells.
Kent Clinics for Nervous Disorders, Margate General Hospital.
Gravesend and N. Kent Hospital, Gravesend.
Royal Surrey County Hospital, Guildford.
Kent County Mental Hospital, Maidstone.
Brookwood Mental Hospital, Knaphill, Woking.


ENGLAND & WALES
PSYCHIATRIC OUT-PATIENT CLINICS
COUNTY & BOROUGH MENTAL HOSPITALS
CERTIFIED INSTITUTIONS & COLONIES
TOWNS SHOWN THUS
SCALE OF MILES
Enlarged sheet showing Region 5
1
2
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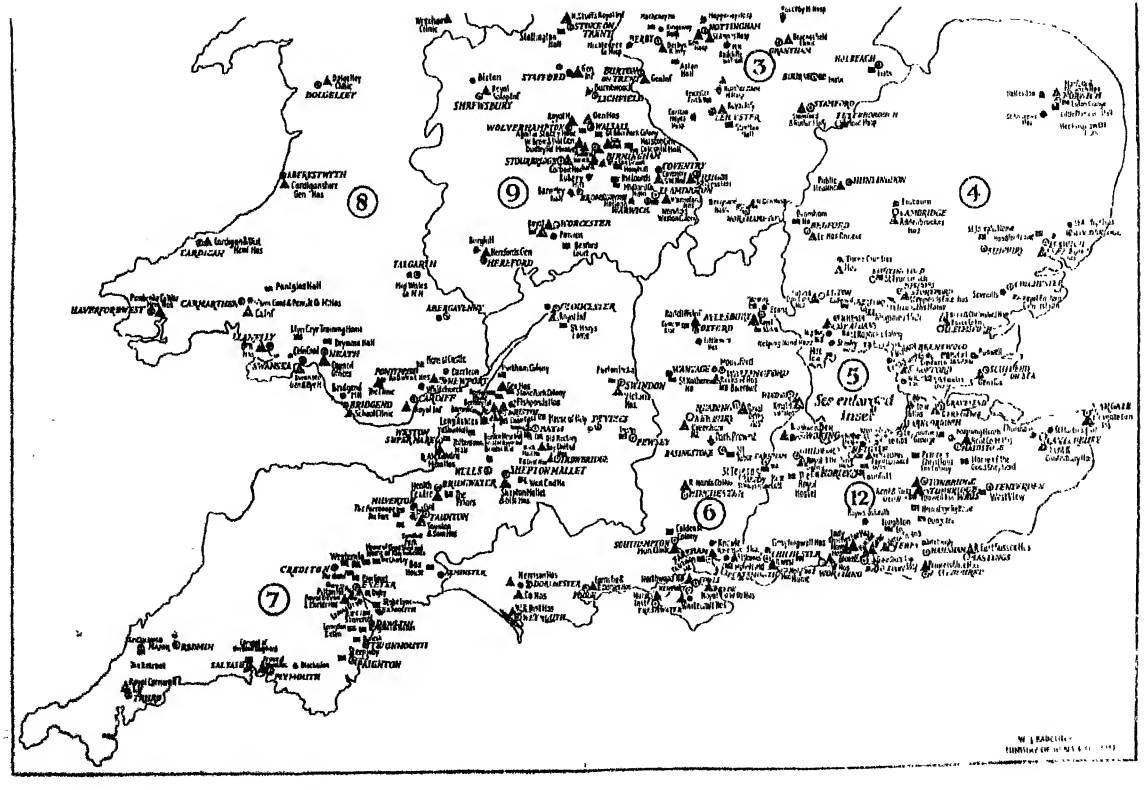
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12
See enlarged inset

APPENDIX VI

CHILD GUIDANCE CLINICS[1]

Region I.

L.A. . . Sunderland Education Committee Child Guidance Clinic, 'Thornfield', Sea View Road, Sunderland.

Region II.

L.A. . . Barnsley Education Committee Child Guidance Clinic, 39 Pitt Street, Barnsley.

L.A. . . Bradford Education Committee Child Guidance Clinic, 28A Manor Row, Bradford.

L.A. . . Leeds Child Guidance Clinic, 8 Park Square, Leeds, 1.

L.A. . . Sheffield Education Committee Child Guidance Clinic, 9 Newbould Lane, Sheffield, 10.

L.A. . . York City Education Committee Child Guidance Clinic, Castlegate School, Yorkshire.

Region III.

L.A. . . Chesterfield Children's Centre, Rye Flat, Chesterfield.

L.A. . . Derby Boro' Education Committee Child Guidance Clinic, Mill Hill Lane, Derby.

L.A. . . Derby County Education Committee Child Guidance Clinic, Dean Hill House, Derby.

V.C. . . Leicester City Mental Hospital Child Guidance Clinic, Francis Dixon Lodge, Humberstone, Leicester.

L.A. . . Leicester Clinic and Education Department, Child Guidance Clinic, Newarke Street, Leicester.

L.A. . . Nottingham Education Committee Child Guidance Centre, 34 Clarendon Street, Nottingham.

Region IV.

V.H. . . Addenbrooke's Hospital, Child Guidance Clinic, Cambridge.

L.A. . . Cambridge Education Committee Child Guidance Clinic, c/o School Medical Dept., Guildhall, Cambridge.

L.A. . . Hertfordshire County Council, Psychiatric and Child Guidance Service, Hill End, St. Albans, Herts.

L.A. . . Norwich Education Authority Child Guidance Clinic, City Hall, Norwich.

L.A. . . Southend-on-Sea Education Committee Child Guidance Clinic, Education Offices, Warrior Square, Southend-on-Sea.

Region V.

Commonwealth Fund of America and Vol. Child Guidance Training Centre, Woodside Hospital, Woodside Avenue, Muswell Hill, N.10.

Vol. . . Creighton House, Child Guidance Clinic, 378 Lillie Road, S.W.6.

[1] This list was prepared in February 1944.

Vol. . .	East London Child Guidance Clinic, 19 Rampart Street, Commercial Road, E.1.
V.H. .	Guy's Hospital Child Guidance Clinic, Dept. of Psych. Medicine, S.W.1.
V.H. .	Hospital for Sick Children, Great Ormond Street, London, W.C.2.
L.A. . .	Hounslow (Borough of Hoston and Isleworth) Public Health Department, 92 Bath Road, Hounslow.
Vol. . .	Institute for the Scientific Treatment of Delinquency, 17 Manchester Street, London, W.1.
V.H. .	London Hospital Child Guidance Clinic, Whitechapel, E.1.
L.C.C. .	Maudsley Hospital Child Guidance Clinic, Denmark Hill, S.W.5.
V.H. .	Middlesex Hospital Child Guidance Clinic, W.1.
L.A. . .	Middlesex County Child Guidance Clinic, 2 St. John's Road, Harrow, Middlesex.
V.H. .	Queen's Hospital for Children, Child Guidance Clinic, Hackney Road, Bethnal Green, E.2.
V.H. .	Paddington Green Children's Hospital, London, W.2.
V.H. .	St. Bartholomew's Hospital, Child Guidance Clinic, West Smithfield, E.C.1.
V.H. .	St. George's Hospital, Hyde Park Corner, S.W.1.
V.H. .	St. Thomas's Hospital, Albert Embankment, S.E.1.
Vol. . .	Tavistock Clinic, Westfield College, 3 Kidderpore Avenue, Hampstead, N.W.3.
V.H. .	University College Hospital Child Guidance Clinic, Gower Street, London, W.C.1.
V.H. .	Victoria Hospital for Children, Child Guidance Clinic, Tite Street, Chelsea, S.W.3.
L.A. . .	Walthamstow (Borough) Child Guidance Clinic, Public Health Department, Walthamstow, E.17.
V.H. .	West End Hospital for Nervous Diseases, 73 Welbeck Street, W.1.
L.A. . .	West Ham (County Borough) Child Guidance Clinic, School Medical Department, 38 Romford Road, Stratford, E.15.

Region VI.

L.A. and M.H. .	Aylesbury Child Guidance Clinic, The Old Gatehouse, Whitehill, Alyesbury. *Sessions at :* Bletchley.
L.A. and M.H. .	Berkshire County Child Guidance Clinic, 27 Kidmore Road, Caversham, Berks. *Sessions at :* Reading, Windsor, Wantage, Maidenhead, Newbury, Abingdon, Faringdon.
V.H. and L.A. .	Bournemouth, Royal Victoria and West Hants Hospital, Shelley Road, Boscombe, Hants.
L.A. . .	Hampshire County Child Guidance Service, The Castle, Winchester, Hants.
L.A. and P.H. .	High Wycombe Child Guidance Clinic, The Municipal Health Centre, High Wycombe.
L.A. . .	Isle of Wight Child Guidance Clinic, The Youth Centre, Quay Street, Newport, I.O.W.
L.A. . .	Oxford City Education Committee Child Guidance Clinic, Northern House, South Parade, Oxford.

L.A. . . Portsmouth Child Guidance Clinic, 101–105 Victoria Road North, Portsmouth, Hants.
Vol. . . The Child Guidance Clinic, Reading University, Reading.
L.A. . . Southampton Education Committee Child Guidance Clinic.

Region VII.

L.A. . . Bath Joint Education Committee, Child Guidance Clinic, School Medical Department, Sawclose, Bath.
L.A. . . Bristol Education Committee Child Guidance Clinic, 1 Argyle Road, St. Paul's Road, Bristol.
L.A. . . Cheltenham, Gloucester and County Child Guidance Clinic, 'Strathmore', St. Luke's Road, Cheltenham.
Sessions at : Gloucester and Stroud.
L.A. . . Exeter Child Guidance Clinic, Pilton House, Richmond Road, Exeter.
L.A. . . Plymouth Child Guidance Clinic, Catherine Street, Plymouth.
L.A. . . Somerset County Child Guidance Clinic, County Hall, Taunton.
Sessions at : Taunton, Bridgwater, Weston-super-Mare.

Region VIII.

L.A. . . Cardiff Education Committee, Child Guidance Clinic, Catherine Street, Cardiff.
L.A. . . Swansea Child Guidance Clinic, 119 Walter Road, Swansea.

Region IX.

L.A. . . Birmingham Education Committee Child Guidance Clinic, 45 Lee Crescent, Birmingham, 15.
V.H. . Birmingham Children's Hospital Department of Child Psychiatry, Ladywood Road, Birmingham, 16.
L.A. . . Stoke-on-Trent County Council, Child Guidance Clinic.
V.H. . Warneford General Hospital Child Guidance Clinic, Leamington Spa, Warwickshire.

Region X.

L.A. . . Manchester Education Committee Child Guidance Clinic, 54 High Street, Manchester, 13.
V.H. . Royal Manchester Children's Hospital, Child Guidance Clinic, Pendlebury, Manchester.
L.A. . . North-East Lancashire Child Guidance Clinic, Public Health Department, Town Hall, Accrington.
Sessions at : Accrington, Rawtenstall and Blackburn.
L.A. . . Oldham Education Committee Child Guidance Clinic, 60 Gainsborough Avenue, Oldham.
L.A. . . Preston County Borough Education Committee Child Guidance Clinic, Infant Welfare Centre, 20 Fishwick View, Preston.
Vol. . . Liverpool Notre Dame Child Guidance Clinic, 2 Maryland Street, Liverpool.
L.A. . . Rochdale Education Committee Child Guidance Clinic, 2 Whitehall Street, Rochdale.
L.A. . . Salford Education Committee, Child Guidance Clinic, 49 The Crescent, Salford, 5.

Region XII.

L.A. . .	Brighton Education Committee Juvenile Care Clinic. School Clinic, Sussex Street, Brighton.
L.A. . .	Canterbury Child Guidance Clinic, Tower House. Westgate, Canterbury.
L.A. . .	Chislehurst Child Guidance Clinic, School Clinic, Chislehurst.
L.A. . .	Croydon Child Guidance Clinic, Mayday Hospital. Croydon.
L.A. and M.H.	Guildford Education Committee Child Guidance Clinic, The School Clinic, 19 Stoke Road, Guildford.
Vol. . .	East Grinstead Child Guidance and Vocational Clinic, 'Moat View', Moat Road, East Grinstead.
V.H. .	Hove Child Guidance Clinic, Lady Chichester Hospital, New Church Road, Hove.
L.A. and M.H.	Reigate Child Guidance Clinic, Billeting Office, Reigate.
L.A. . .	Surrey County Council Child Guidance Services. *Sessions at :* Redhill, St. Helier and Woking.

KEY TO SOURCES OF FINANCIAL SUPPORT

L.A. = Local Education Authorities and County Councils and City Corporations.
M.H. = Mental Health Evacuation Account.
V.C. = Partly maintained by Visiting Committees.
Vol. = Voluntary Funds.
V.H. = Within a Voluntary Hospital and maintained by Hospital Funds.

APPENDIX VII

Drawings of Psychiatric Units and Clinics.

Certain drawings, prepared by Mr. F. Coutts Webster, architect of the Board of Control, are available at the Ministry of Health for authorized persons to see. These drawings have not been reproduced in the report because, with further experience, they may be altered and improved.

The drawings are not intended as precise specifications; they have been prepared and assembled more with the object of providing University Authorities and Local Authorities with certain basic ideas as to the requirements of psychiatric units and clinics which can be adapted to local needs.

A psychiatric clinic has no beds: it consists only of an out-patient department. A psychiatric unit includes an out-patient department, but also contains beds in the same building. The drawings include the following:

A. Psychiatric Clinics.

1. A clinic for a non-teaching unit, with a central waiting-room enclosed on all sides.
2. A similar clinic with a central waiting-room one side of which gives on to an open space.
3. A clinic for a non-teaching unit with a corridor in place of a central waiting-room. This structure is cheaper to build than 1 and 2.
4. A clinic for a teaching unit with central waiting-room as in 1. There are included here more consulting and examination rooms than in the first three drawings.
5. A similar clinic to 4, but with the central waiting-room unenclosed on one side as in 2.

B. Psychiatric Units.

These include a psychiatric clinic as in drawings 1 to 5, but also have a variable number of beds.

6. A non-teaching unit with an out-patient department as in 3, and with two wards with 12 beds each.
7. A teaching unit for a country site with space for building. Out-patient department as in 4, and about 70 beds arranged as described on page 64.
8. Same as 7, with alternative arrangement for the out-patient department.
9. A unit of same capacity as 7, but adapted to a town site where space is limited.

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